LIFTING THE LID ON PANDORA'S BOX

TRAINING FAMILY DOCTORS IN THE DETECTION AND MANAGEMENT OF INTIMATE PARTNER ABUSE/DOMESTIC VIOLENCE

Angela Joy Taft BA Dip Ed MPH

A thesis submitted for the degree of Doctor of Philosophy of the Australian National University

September 2000

Except where otherwise indicated, the work in this thesis is my own, and is based on original research conducted while I was a PhD student at the National Centre for Epidemiology and Population Health, ANU

Angela Taft

ACKNOWLEDGEMENTS

I would first like to acknowledge my unstinting gratitude to my wonderful supervisors and friends, Drs Dorothy Broom and David Legge. Both offered unwavering belief in the study and vital encouragement and support to me personally. As well as challenging my thinking, both Dorothy and David helped me to find conceptual clarity among the many uncertainties and to craft the verbal clay into better sculpted form. Professor Bob Douglas guided the early stages of the study and as Director of NCEPH, gave NCEPH's institutional support, which administered and financially supported both the conduct of the study and me as an external doctoral student.

The study could not have been conducted without the generous support of staff at the two GP divisions, but most importantly I am grateful for the generosity and inspiration of the many doctors who gave their time to be interviewed. The seven case doctors gave many precious hours to share their practice and concerns with me, and the two GP project managers their time and constructive feedback.

Bonnie Simons ably transcribed all the data. At NCEPH, Colin McCulloch and his staff responded helpfully to any computer needs. Jean Hardy, Virginia Riddle, Kaye Devlin and Valda Gallagher made my many trips to and from Canberra problem free and my colleagues provided stimulating discussion. The staff and other postgraduate students of University House, ANU accommodated my homesickness and provided opportunities for inspiration in walks around Lake Burley Griffin and drinks in Fellows Gardens. In between times, Manoa Renwick's generosity offered a home away from home. As the study progressed, I became enormously grateful to Professor Judith Lumley, her staff and students at the Centre for the Study of Mothers' and Children's Health for a supportive environment and a stimulating, collegial and hardworking atmosphere in which to write up this study. Dr Therese Riley deserves special thanks for sharing methodological and ethical moments of angst and my roommate, Dr Lisa Amir for her friendship and support.

I am very grateful in particular to Dr Kelsey Hegarty and also to Dr Elizabeth Hindmarsh for their constructive comments and many stimulating and informative discussions about the nature of partner abuse, general practice and GP education. Thanks are also due to Vig Geddes and Margot Scott and staff at DVIRC, staff at No To Violence (formerly Victorian Network for the Prevention of Male Family Violence) and Dr Ron Schweitzer. Dr Ilana Snyder, loyal and ever-encouraging friend and sometime editor deserves my very real gratitude for her enthusiastic help.

Lastly, but most importantly, my ever-loving debt to the patience and love of my three young people, Rebecca, Georgia and Shura and together with his beautiful music, great coffee and cooking always to my ever-enduring husband David.

Australian National University

Abstract

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by Angela Taft

Chairperson of the Supervisory Committee: Dr Dorothy Broom

National Centre for Epidemiology and Population Health

Abstract

Family doctors (GPs) are potentially important sources of support and advice for victimised women, but also for men who abuse and their children. To date, most clinical guidance and training for doctors has focussed on the GP's role with the female victim and has not fully incorporated the implications of the doctor's relationships with other members of the family. The broad aim of this study was to explore the ways GPs work with all members of a family in which partner abuse occurs and to suggest what further continuing medical education they might require.

The study, embedded in feminist and social theory, uses multiple interpretive methods, drawn from ethnographic and process evaluation methodologies. These methods were employed in case studies of two domestic violence continuing medical education training projects: one in a rural, the other in an inner urban and culturally diverse area. The views of 28 GPs and of many other educators, specialist workers, policy-makers and men who abused were sought through interviews (130) and focus groups (5). Drawing on successive interviews with seven doctors (interviewed on average every two months, up to seven times), detailed narratives of GP/patient interactions were constructed. Training sessions were also observed (10) and surveys of participants conducted before and after training.

The GPs studied managed a complex range of partner abuse scenarios. Their perceptions of female and male patients were filtered through the shifting patterns of attitudes and beliefs through which their own identities were constructed. The doctors' clinical management illustrated tensions between the theories and practices of family medicine and domestic violence. For some family doctors, tensions between family-centredness and the individual patient/doctor relationship created problems in the management both of couples and of parents and children. The study data highlight both the particular problems the GPs faced with male patients who abuse and those the men faced with their ill health and with GPs. Most doctors in the study were not alert to the risks which children face and were unaware that asking about the impact on children could serve as a significant lever for beneficial change for patients.

The GPs generally felt under-skilled in counselling ranging from couple counselling to 'holding' strategies and crisis counselling. Without the support of professional supervision and debriefing, many were stressed by the additional demands of the counselling necessary for partner abuse. The doctors also illustrated difficulties with the complexity of disclosure and referral processes required in partner abuse cases and partner abuse case management.

Training enhanced the GPs' confidence and knowledge of strategies and resources. Greater role clarification reduced the GPs' stress. However overall, the teaching needed to more effectively challenge the GPs' beliefs and attitudes hindering their capacity to: directly inquire and identify victims; empower those victims who are not ready to leave; challenge abusers' behaviour; or recognise and effectively manage the needs of children who witness violence. It also dealt inadequately with the dilemmas of working with both partners. Cross-cultural and gender issues, not tackled in education, would benefit from an emphasis on 'mindful' practice. The study proposes a comprehensive conceptual framework for an integrated training strategy.

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DEFINITIONS AND ABBREVIATIONS

Definitions

The term domestic violence is used interchangeably with intimate partner abuse in this thesis.

For the purposes of this study, I define domestic violence or partner abuse as systematic physical, sexual, psychological, emotional, economic or spiritual abuse of one intimate partner by the other, almost always male, to control their behaviour or intimidate them.

In order to distinguish it, family violence can be defined to include similar forms of abuse perpetrated by any family member on another and covers intimate partner, child, sibling and elder abuse.

Abbreviations

ABS	Australian Bureau of Statistics
ATSI	Aboriginal and Torres Strait Islander
CASA	Centre Against Sexual Assault
CAT	Crisis Assessment Team (mental health service)
CHC	Community Health Centre
CME	Continuing Medical Education
CSA	Child Sexual Abuse
CSV	Community Services Victoria (former child protection service provider)
CTS	Conflict Tactics Scale
EFT	Equivalent Full Time
ESB	English-speaking background
FMP	Family Medicine Program (RACGP)
FP	Family Practitioner
GP	General Practitioner
NESB	Non English-speaking background
NSW	New South Wales
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
TAFE	Technical and Further Education (College)
VAW	Violence Against Women
VIC	Victoria
WAVP	Women and Violence Project

CHAPTER ONE: INTRODUCTION AND OVERVIEW

Violence against women and children is a serious and prevalent issue in Australia as it is worldwide. One of its manifestations, intimate partner abuse or domestic violence, is a difficult and confronting issue to deal with for any welfare or health professional. It can evoke feelings about one's own intimate relationships and repugnance at the violation of intimacy. It brings concepts of human rights into the family, challenges the limits of privacy and raises the uncomfortable politics of gender. These unsettling ideas can also affect the work of the family medical practitioner.

Australian general practitioners (GPs) are working in an environment of rapid change and escalating demands. In addition to working in a newly restructured environment, they are increasingly asked to be multi-skilled, technologically literate, up-to-date with the latest evidence-based medicine and active and sensitive communicators with growing numbers of depressed and disempowered patients. They are expected to achieve all this in a fee-for-service system.

Victimised women and children confront the family doctor with serious challenges. One such woman was Heather Osland, currently serving a fourteen and a half year sentence for her role in the killing of Frank Osland, her brutally abusive husband of over thirteen years. Heather suffered from the chronic health problems familiar to all who know the effects of partner abuse. She visited her family medical practice repeatedly over the years of abuse, both with her children and without them. Her husband, Frank Osland, also did. After his death, her family doctor's inadequate evidence and documentation failed Heather in court in the same way as did the overall criminal justice system. Doctors like Heather's can be found all over Australia. Like most GPs, he was not trained to deal with Frank's obvious brutality nor the scale of Heather's needs. Consequently, Heather and many other seriously abused women felt deeply disappointed by those they consider have moral and professional power and authority in the community. In Heather's case, the consequences were grave. Could the outcome have been different?

I have been working and researching in primary care and women's health for many years. While employed in women's health policy and program areas for the Victorian Department of Health and Community Services, I became involved with family violence services and aware of the beneficial potential of GPs' interventions in the lives of women and children living with violence. In addition, I conducted Masters level research into abused women's experiences with GPs, which formed the inspiration for this study. I heard women's desperation and frustration with inappropriate GP responses and overwhelming gratitude when the response was supportive and informed. I grew to understand how their children suffer and how the cycle may continue. I learnt that many wanted help for their partners as well as for themselves and their children. I understood how inadequately informed and ill-equipped GPs are to meet such needs and how their role in society's overall response has never been adequately defined or supported. This study has been

conducted to contribute to the over-arching goal of improving the public health response to this serious and prevalent problem in our community.

I have called the study "Lifting the Lid on Pandora's Box". This metaphor 'lifting the lid' refers to the action taken by the women's movement to expose the violence that went on inside the privacy of the family home. Doctors frequently and spontaneously use the term 'opening Pandora's Box' to describe their fear in looking more closely at partner abuse, at 'lifting the lid' on what is happening in their patients' intimate lives. Understandably, doctors do not want to be overwhelmed by situations and feelings they cannot control and for which they have not been prepared.

Pandora is a Greek mythological character, deemed responsible for releasing disaster and misery on mankind, by opening the lid of a box intended for Prometheus, which the 'gods' forbade her to open. This myth is about male power, control, punishment and women's 'flawed' nature and seductive, submissive role. However, according to the myth, the only good thing in the box was Hope - humanity's sole comfort in misfortune. The myth is symbolically rich for this study.

This thesis has proved difficult to write. I have struggled to find the best voice among those in my own professional range (the collection of voices I have accumulated over the years to articulate different experiences). This thesis incorporates a modulation of my epidemiological voice, struggling to harmonise with the voices of social theory, public health and Australian feminisms.

The next chapter provides the context for the study. It examines theories about the causation and prevalence of domestic violence and describes the health impact of abuse on all members of the family. I survey the prevalence of victims and abusers among GP patient populations, practitioners' responses and highlight the importance of the GP as a critical gatekeeper to early intervention and support. I explore some of the tensions between family medicine and domestic violence, the dynamic context of contemporary Australian general practice and the implications and impact of feminisation on general practice in this country as elsewhere. I describe the current developments of medical education around domestic violence and the difficulties with its evaluation.

Chapter three outlines the qualitative ethnographic methods used to conduct the study: the two projects, which were the context for the study, are described followed by the questions the study addresses. The design, rationale and theoretical orientation precede a more detailed exposition of the data collection phase and the research dilemmas encountered during this phase. Lastly, I outline the analytic processes.

Chapters four, five and six outline the major findings. Chapter four presents the ways in which doctors prior to training, describe the complex abuses reported in consultations with their patients, the diversity of men, women and couples whom they see and the attitudes doctors reveal in their discourse about abuse patients. I note the absence of children in many doctors' accounts.

Chapter five describes how doctors manage couples and individual men and women before training. I outline different patterns and beliefs underpinning doctors' identification and management practices with couples, individual female and male patients. These are compared with current management principles, key stakeholder perspectives and what women and men ask for both in the literature and in this study. I explore the centrality of counselling to management and discuss some of the difficulties GPs describe. I also report on the paucity of the identification of affected children's needs and any appropriate management.

Chapter six describes the implementation of two GP Continuing Medical Education domestic violence projects and reports on how this education impacted on participant doctors' attitudes, knowledge and practice. I account for the major facilitating factors and suggest strategies which would have enhanced the projects' effectiveness. I also compare the achievements of two doctors who undertook the greatest amount of training to highlight current CME achievements and the challenges which remain.

The final chapter explores the implications of the key findings for general practice, medical education and policy. An integrated curriculum framework for partner abuse education in general practice, outlining key conceptual areas, completes the thesis.

CHAPTER TWO: A STRIFE OF INTERESTS[1] - INTIMATE PARTNER ABUSE, GENERAL PRACTICE AND MEDICAL EDUCATION

2.1 Introduction

This thesis is concerned with domestic violence or intimate partner abuse, (more specifically abuse by men of their female partners), which is the majority of cases as defined in this study. In this chapter, I analyse the literature informing the three central domains of the study:[2] intimate partner abuse, general practice and medical education, to outline the background to the study. I chart how explanations for domestic violence have shifted from the individual into society and why contemporary theory privileges the role of gender and power. I consider evidence that not only is partner abuse prevalent in the Australian population, but more prevalent in general practice patient populations due to its serious health effects, underscoring the potential of the general practitioner as a source of advice and support. I consider evidence that both victimised women and men who abuse are present in GP patient populations and that partner abuse causes serious health damage to both partners and to children who witness it or are abused themselves as well. I discuss how GPs' responses to patients experiencing partner abuse are hampered by their lack of expertise. I also describe how current family medicine training is restricted by the contradictions inherent in family medicine constructs when applied to partner abuse and by the almost exclusive focus on female victims. I outline the current status of medical training about the issue in Australia and overseas and review dilemmas in current medical education evaluation methodology.

2.2 Domestic violence - contested theories, opposing definitions and flawed solutions

The study of domestic violence has been a politically charged and controversial area, characterised by contestation within epidemiology and the social sciences (Yllo 1988). This debate centres on differing definitions of domestic violence arising from differing causal theories, research methodologies and the consequent data. Such decisions about theories and definitions are critical to data collection and conceptualising policy and program responses to prevent abuse or respond to people suffering from it.

Prior to the 1970s, domestic violence was thought to be relatively infrequent and the cause to lie in the psychopathology of the individual family members involved (Dobash and Dobash 1992). It

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[1] This title borrows from the seminal book by Sax, Sidney (1984) A Strife of Interests: Politics and Policies in Australian Health Services, Allen and Unwin, Sydney.

[2] To do so, I searched the PubMed, APAIS, Cinahl, Sociofile, and Psychlit databases using the following keywords: domestic violence, family violence, spouse abuse, partner abuse, wife abuse, woman abuse, wife battering (separately and together with) general pract* or family pract*. I included the terms counselling or (continuing) medical education (CME) with the previous terms. The search covered 1990-98 to supplement the references from my previous study. My own professional networks contributed additional Australian policy and program documents associated with these topics.

was, as Knight and Hatty describe '*not considered to be problematic. It was privatised, individualised, medicalised and de-politicised* (Knight and Hatty 1987). A range of partial, contradictory and flawed explanations emerged to account for it, some of which are still evident:

(i) privatisation (the problem is located in the family)

(ii) medicalisation (violence is a manifestation of pathology)

(iii) normalisation (violence occurs along a normal behavioural continuum)

(iv) victimisation (presents the victim as agent provocateur)

(v) equalisation (partners share equal responsibility for the violence)

(Hatty 1985).

Evidence for the nature of intra-familial violence in the seventies was almost exclusively gathered from unrepresentative clinical samples of men in prisons and women from refuges. Violence was thought to reside largely in working class families and ethnic minorities (Women's Policy Coordination Unit 1985). Psychologists examined the psychopathology of male perpetrators and female victims. Women victims were blamed for violating family norms and frequently typecast with features resulting from their victimisation, rather than those theorised to have caused it. They were labelled inadequate or masochistic and men as abnormal (Gayford 1975; Pagelow 1978; Herman 1992).

As the women's movement re-emerged during the 1970s, feminists critiqued the androcentric bias of sociological analyses and overturned the concept of the family as a refuge from external dangers by exposing the violence within its walls (Pizzey 1974). Feminists theorised the relationship between male power and control of social institutions and male violence, particularly towards women. They argued that domestic violence extended male abuse of power and control over women into intimate relations (Pagelow 1978; Edwards 1987). Feminist women opened their doors to protect abused women. The origins of the refuge movement therefore commenced with the lay protection of escaping women, rather than the welfare sector. Later, governments provided funds for refuges and welfare professionals working in them (McGregor and Hopkins 1991). Separately, but at the same time, the medical profession raised concern about the abuse of children in families. Consequently, domestic violence and child abuse developed as distinct issues and areas of professional expertise (Family Violence Professional Education Taskforce 1991).

Arising from the women's movement's gender analysis, pro-feminist researchers began to explore the problematic nature of forms of masculinity encouraging men to be either violent or abusive in their intimate relationships (Connell 1987; Morgan 1987; Segal 1990; Bowker 1998). Criminologists explored forms of masculinity, such as domination, control and humiliation of women and those of disregard and unconnectedness associated with violent and anti-social male behaviour (Braithwaite and Daly 1994). With the increasing focus on gender as problematic and dynamic, several strands of the 'men's movement' emerged, taking wide-ranging positions on the

causes and solutions of male violence to women. These groups have been described by Flood as those from pro-feminist and men's liberation (which acknowledge men's power and control and challenge aggressive socialisation processes) through to the oppositional men's rights groups. Men's rights groups do not acknowledge men's greater power and blame feminism for creating discrimination against and victimisation of men (Flood 1996).

In the United States and England, in association with women from the refuge movement, pro-active men established male behaviour change groups to help men who abused women to alter their behaviour. Most of these groups provided pro-feminist educational interventions to men mandated by the courts to attend groups. More recently in Australia, disparate groups have been established, with a variety of theoretical and methodological approaches, for voluntary and court-mandated men. Many groups, but not all, are pro-feminist and their evaluation and effectiveness remains controversial (Keys Young 1999).

2.2.1 Major explanatory theories

Major contemporary theories about the causes of partner abuse cohere in a few major areas. These theoretical groupings have influenced most studies of violence in families. Clinical psychology (sometimes referring to interpersonal violence theory) examined individual traits, deficits and psychological disorders in clinical samples of women and men and focussed on the deviance and psychopathology which can lead to violence (Dutton and Painter 1981; Herman 1992; Eiskovits, Edleson et al. 1995). Such pathology, low self-esteem or drug and alcohol abuse were considered the causes rather than sequelae of violence, and interventions focussed on therapy, individual or conjoint. Whilst sometimes helpful for individuals, therapeutic remedies are not useful for a population health approach to domestic violence (Stark and Flitcraft 1991).

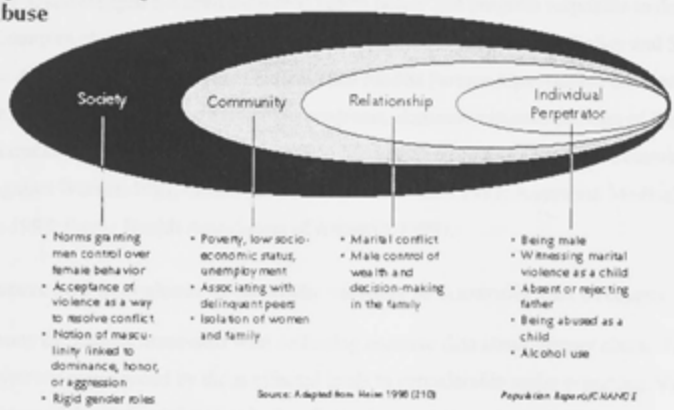
The remaining major, overlapping but often oppositional, theories concern the sociology of family violence (family systems and conflict theories), social learning and feminist theories. Family system theorists emphasise the importance of social structures and systems, in particular the family, and ways the institution of the family allows or encourages the violence within it (Gelles and Loseeke 1993; Alpert 1999). The intimacy and privacy distinguishing the family as a group and family members' normative support for violence as a solution to conflict, are thought to lead to partner, elder, sibling and child abuse. This theory often incorporates aspects of social learning that argues both victimisation and perpetration are behaviours learnt in the family. While the evidence is less strong for female victimisation, there is substantial evidence for learnt male perpetration, as having experienced or witnessed violence was found to be common in the backgrounds of men who abuse (Sugarman, Aldarondo et al. 1996). The different meanings, consequences or gender dynamics of abuse by different sex partners, children or elders is less important in family systems theory than the conflict tactics. While some social learning theorists explore the role of gender, family violence theorists are less concerned with the consistency of gendered patterns of violence in families and the broader society, than with the power and

resource differentials within the family system (Hotaling and Sugarman 1986; Stark and Flitcraft 1991; Birns, Cascardi et al. 1994).

Feminist explanations of violence against women, in which they include intimate partner abuse, are sometimes seen in opposition to the family systems perspective, which they criticise for being gender neutral. Feminists emphasise women's lived experiences and articulate theory about how patriarchy, or the global control and power which men exercise in all countries, permeates society and is borne by women and children in the family. This exercise of power is manifested in the many forms of abuse which women and children experience from the men who have control over them. Patriarchy can be found at the societal and institutional, local, intra-familial and inter-personal level. Advocates argue that feminist theory 'is not a narrow theory of one aspect of family violence. It is a broad analysis of gender and power in society that has been fruitfully applied to domestic violence' (Yllo 1988 p49).

Heise proposes an ecological model of factors associated with partner abuse, which recognises the inter-relationships of extra-familial factors impacting on a man's decision to abuse his partner. The model incorporates feminist, social learning and other sociological theories. The Ecological Model accounts for variations in social, cultural and religious norms within countries, different socio-economic groups and factors in a man and his partner's families of origin (Heise, Ellsberg et al. 1999).

Figure 1. Ecological Model of Factors Associated with Partner Abuse



Clinical and justice data provide evidence for patterns of male abuse and female victimisation within families. Criminological and sociological research furnishes evidence for the rates of general and more specific violence perpetrated by men against other men and women. Criminologists argue that at all times and in all places men commit the vast majority of violence as men channel their aggression outwards and women inwards (Morgan 1987; Stark and Flitcraft 1994).

No one theory adequately explains all aspects of abuse between intimate partners. There is growing agreement that intimate partner abuse is multi-faceted, complex and requires contingent theoretical perspectives, but while a gender perspective is not sufficient, it is necessary, because patriarchy is central to understanding partner abuse in the wider social context of violence against women (Yllo 1993; Alpert 1999).

2.3 Violence against women as a public health issue

International bodies now recognise that violence against women is a leading cause of health damage with major social and economic consequences (Heise, Ellsberg et al,1999). Advocates for women point to systematic rape in war, the sexual slavery of women and girls and culturally sanctioned forms of anti-female violence, such as female infanticide and abortion of female foetuses as evidence of overt or implicitly state sanctioned violence against women (Alpert 1999). Violence against women is prevalent globally. Wife beating is the most common form of violence in families in any human society studied, followed closely by child abuse. It occurs more frequently in the early years of marriage and when children are present (Levinson 1989). Flitcraft writes that 'the epidemiology and clinical dimensions of rape, physical and sexual assaults in marital, cohabiting and dating relationships and long-term effects of childhood sexual abuse - unveils women's vulnerability to violence across the lifespan' (Flitcraft and Follingsted 1992 p3194). This suggests a gendered pattern of risk exposure (Broom 1999).

Australia has acknowledged the need for public health policy and program responses to domestic violence. Examples of national public policy responses include: The National Policy and Strategy on Violence Against Women; the recent federal/state funded Partnerships Against Domestic Violence program; National Crime Prevention programs; domestic violence policies of the Public Health Association of Australia and the Australian Medical Association (National Committee on Violence Against Women 1992; Office for the Status of Women 1997; Australian Medical Association 1998; Public Health Association of Australia 1999).

2.4 The nature and prevalence of domestic violence in Australia and overseas

There are many difficulties associated with collecting accurate data about partner abuse. The fear, shame and secrecy experienced by those affected leads to considerable under-reporting. Victims and perpetrators of domestic violence, whether disclosing or not, present to a wide range of health and welfare agencies, including police, courts, refuges and medical services. In addition to reluctance to disclose, problems amassing data include:

- non-standard definitions of domestic violence
- under-reporting by agencies
- inadequate detection and recording of domestic violence

- incompatability of data sources and
- lack of uniformity in collecting statistics across the different data sources (Sherrard, Ozanne-Smith et al. 1994; Ferrante, Morgan et al. 1996).

The common exclusion of non-English-speaking background (NESB) people from research studies contributes to under-reporting (Roberts, cited in Sherrard, Ozanne-Smith et al. 1994). Additionally, survey-screening tools may not have been validated cross-culturally which can result in flawed estimates (Campbell, Campbell et al. 1994).

Australian police and criminal justice data referring to intimate partner abuse suffer from many of the above problems. Up until 1999, as well as differing legal definitions of domestic violence and under-reporting, the data were not comparable across jurisdictions, due to different reporting practices and requirements (Ferrante, Morgan et al. 1996). From 1995 agreed categories for assault, age, sex and relationship to victim were included in police data and from January 1999, the classification of national police crime statistics was altered to improve state and national comparability (Australian Bureau of Statistics, 1999). Data from Australian courts about intervention or restraining order data used in relation to partner abuse are not yet comparable across states and territories.

Differences in measurement tools may result in differing prevalence rates. In a review of Australian and overseas population prevalence studies of domestic violence, Hegarty and Roberts compare different prevalence rates when survey responses do not elicit frequency or severity of abuse, are restricted to physical acts regarded as criminal or are broadened to include emotional and other forms of abuse. In particular, they criticise the current 'gold standard' Conflicts Tactic Scale (CTS), as it measures every physically aggressive act, regardless of context, intent or outcome. They contrast the widely differing Australian incidence rates from 2.1% of female victims of intimate criminal assault to 28% of any form of partner abuse against women, counting any one act as inherently abusive. They conclude that researchers may be discovering differing forms of violence, such as the 'common couple violence' and 'patriarchal terrorism' suggested by Johnson (1995) and that a new tool is required which includes measures of intent, frequency and severity (Hegarty and Roberts 1998).

2.4.1 Telephone surveys

In Australia in the 1980s, following pressure from feminist advocates, several state governments conducted research to investigate the level of partner abuse in their state and what could be done about it (Women's Policy Coordination Unit 1985; Queensland Domestic Violence Taskforce 1988). Literature scanning, interviews and phone-in surveys were the major source of information about women's abuse experiences, help sources to which they turned and service responses to women. Telephone surveys have considerable self-selection bias (Ferrante, Morgan et al. 1996).

In these studies, researchers included questions about women's perceptions of doctors as sources of help.

A 1982 Victorian phone-in elicited calls from 487 women who answered questions about their abuse by male partners (Queensland's survey is included in parentheses for comparison). The Victorian survey was limited by its sample size and a poor response from blue collar and NESB women. However, it was noteworthy in the level of violence reported by better-educated women. Anglo-European women, aged 30-49 comprised the great majority of respondents. Over 75% were married, although it was not reported whether to the abuser or to another man. Over half reported they had been abused at least monthly (63% Qld), 28% weekly and 20% daily. While 65% Victorian women (85% Qld) reported that the violence commenced after marriage, 93, ie 19.1%, (20% Qld) reported that it occurred before they lived together, with 8% referring to violence commencing during a pregnancy or after the birth of a child. 71% reported their children had witnessed the violence. While half the women said they submitted, 19% (24% in Qld) fought back. 32% reported either staying for the children's sake or 28% for economic reasons. 37% of Victorian victims had sought help from a doctor. The doctor was the person to whom most women had turned (Women's Policy Coordination Unit 1985).

A 1998 Australian purposive sample survey of over 120 women sought responses from marginalised women, (Aboriginal, disabled, lesbian and migrant women) to explore the diversity of women's help-seeking strategies. The majority experienced combined forms of abuse, including sexual and financial abuse. Women spoke of abuse commencing early in the relationship, when they were pregnant or had first arrived in Australia. Post-separation abuse was common. The report emphasised the diversity of women's circumstances and help-seeking strategies (Keys Young 1998).

2.4.2 Population prevalence studies

Population studies of domestic violence are often limited by their reliance on the use of a modified Conflict Tactics Scale (CTS) to measure rates of partner abuse. The 1996 Australian Bureau of Statistics (ABS) national randomised cross-sectional survey of violence against women measured rates of violence from intimate partners, both male and female, using definitions of criminal physical and sexual abuse or threats of these and added emotional abuse and harassment. They attempted to compensate for the limitations of the CTS by adding additional measures of severity and frequency and including sexual abuse (Australian Bureau of Statistics 1996). Australian population studies result in similar lifetime female partner abuse rates, (one in three or four women experiencing abuse in a lifetime), as those of roughly comparable countries, such as Canada and the US. The ABS study also sought information on levels of fear and help-seeking strategies.

Table 1: Population prevalence rates by country, sample, method and definition

Country	Sample size	Sample type	Method	Definition	Incidence (%)	Lifetime Prevalence (%)
Australia (ABS) (1996)	6300 women	National random sample	Personal interview	Threats of, or actual physical or sexual assault or stalking liable to legal sanction	2.6 (currently partnered) 7.3 (younger women)	23 (42 separated or divorced)
Statistics Canada (1994)	12,300 women	National random digit-dialling	Telephone interview	Physical and sexual assault liable to legal sanction	3.0	29
US (1975) (Straus et al)	2143 couples	National random sample	Personal interview	Physical abuse against female partners	12.1 (3.8-severe)	30
US (1985) (Straus et al)	3520 couples	National random sample	Telephone interview	Physical abuse against female partners	11.6 3.4 - severe)	28

The US studies only interviewed men and women in intact couples, ie those currently in a relationship. They found comparable rates of violent acts by both women and men, leading to the development of the 'battered husband' syndrome (Straus and Gelles 1986). It is clear that excluding separated or divorced women seriously skews the data. It is not clear what the impact of excluding separated men makes. In comparison with the US findings, the Australian Bureau of Statistics (ABS) study, which interviewed partnered, separated and divorced women, found that 42% of women who had been in a previous relationship experienced violence from a former partner, compared with 8% women who experienced violence from their current partner. A 1999 Australian study also using the CTS, reporting only on physical acts between currently partnered men and women found similar rates of male and female violence to the US study. This study was also limited by: no definition of domestic violence, no denominator or response rate given, frequency rates collapsed into violence or no violence and no reported refusal rate (Headey, Scott et al. 1999).

In the ABS study, several clearly at-risk groups emerged. Consistent with other Australian and overseas studies, a high proportion of young women aged 18-24 (19%) had experienced physical and/or sexual violence in the last twelve months. Forty two percent of women who were abused by a male partner, reported abuse in pregnancy. Sixty one percent of those who experienced violence from a current partner reported they had children in their care and 36% (46% of ever-partnered women) said their children had witnessed the violence. A third of women who reported violence from their male partners had experienced some form of abuse as a child. From one in twenty rising to almost one in five women in a current relationship lived in fear, depending on the

frequency of abuse. Also depending on how frequently they had been abused, from one in five to over 90% of women who had left their partner reported having lived in fear of him.

2.4.3 Police and crime victimisation data

Ferrante et al critically reviewed many Australian and overseas surveys of criminal domestic violence, including crime victimisation and police data. Their own West Australian 1994 crime victimisation study found incidence rates similar to the ABS. Women were thirty times more likely to report partner abuse than men. They found evidence of a strongly graded relationship between partner violence and socio-economic status, with the highest rates of partner violence in the most disadvantaged communities. They concluded that Aboriginal women and women from disadvantaged areas were clearly at greater risk of abuse than other women (Ferrante, Morgan et al. 1996).

Recent national data from police statistical sources indicates that women are most often assaulted in private dwellings and that, similar to men, the group most at risk is in the 20-24 year old age group. In those jurisdictions where the relationship to offender is recorded (over 80%), women are more likely than men to have been assaulted by someone they know (Australian Bureau of Statistics, 1999).

The same patterns are evident in national homicide data. These data demonstrate that 125 (on average) Australian females of all ages are killed each year, overwhelmingly by men, most often their intimate partners. In the nine years from 1989 to 1998, 94% of adult female victims were killed by men, 61% of whom were intimate with them. Similar to assault rates, 21-23 year olds are at highest risk of being killed. Overall, Aboriginal and Torres Strait Islander (ATSI) people are at far greater risk than non-ATSI victims of being killed by an intimate partner, with ATSI women comprising 15% of murder victims and ATSI men 12.3%., although they comprise only approximately 2% of the population. Alcohol is strongly associated with partner murders in ATSI cases. Nationally, the trend in murders of female partners is downwards from 147 in 1990/91 to 111 in 1996/7 (Mouzos, 1999).

Thus, the evidence to date suggests that one in four or five Australian women have experienced some acts of physical or sexual abuse in their lifetime and just over one in forty in current relationships have experienced abuse in the previous twelve months. Overwhelmingly the abuse is perpetrated by their intimate male partners. Many have lived in fear of their partners and others still do. The discrepancies in prevalence findings suggest differences in methodologies and possibly differing forms of partner abuse, but that more detailed research needs to be done on the contexts, motives, frequency and outcomes of abuse by women. These data suggest that some men may also be experiencing partner abuse, although probably not the same levels of fear. The experiences of men should be further researched.

The data also suggest which Australians may be more at risk of partner abuse. Young women, particularly if they experienced abuse as a child, are at risk. When women cohabit with an abusive

partner, they are likely to be abused when pregnant and their children to be exposed to violence in the family. Australian women abused by partners separate or divorce in greater numbers than those who remain, but may still be liable to abuse when separated. Women are more at risk of being killed by their intimate partners than men are, particularly if they are of Aboriginal and Torres Strait Islander background. Women of lower socio-economic status are more at risk than those more advantaged. Lesbian partner violence was also noted in the ABS survey, as some perpetrators were female partners. Overseas studies have reported partner abuse among male homosexual relationships (Letellier 1994).

2.4.4 Domestic violence among culturally and linguistically diverse or non-English speaking communities (NESB)

In Victoria, NESB women are over-represented among those seeking refuge in domestic violence crisis services (Merlo, Foard et al. 1994). The ABS survey did not find any higher prevalence of violence among overseas born women, but among those born in non-English speaking countries, in contrast with a clinical study which found no difference in NESB women (de Vries Robbe, March et al. 1996). Nationally, NESB women are over-represented as victims of domestic homicides. They experience many barriers to disclosure and may be unable to access assistance in time (Easteal 1996). This is particularly notable among those who come to Australia as sponsored brides, such as Filipinas, who may be the victims of serial sponsorship, where someone sponsors a spouse or fiancé from overseas more than once, and at least one of the relationships has resulted in some form of abuse or exploitation of the sponsored party, usually a woman (Immigration Advice and Rights Centre 1994). Refugee women suffer doubly if they come from war-torn countries, or those with military intimidation. Their level of fear and the tendency to respond as they would in their country of origin can militate against seeking help (Frye and D'Avanzo 1994). NESB families also face higher rates of unemployment. They face the trials of adjusting to a new society, together with the potentially unsettling role changes, which can occur between spouses and between children and parents in a new culture. Women may become more economically and emotionally dependent on their husbands, which can increase an abusive man's level of power and control. Zaian found that in South Australia, women's economic inequality strengthened male control in the family and together with their reluctance to divorce, contributed to victimised women's suffering, particularly in those communities where women were long regarded as men's property. The experience of racism can further contribute to women's fear and isolation (Zaian 1997).

2.4.5 Violence against Aboriginal and Torres Strait Islander (ATSI) women

ATSI people have suffered violent colonisation by Europeans. Loss of land and freedom, murder, rape and sexual slavery of women, the forced removal of children and their consequent institutionalisation are some of the damaging consequences of colonisation. Colonisation, including the introduction of alcohol, has had a terrible impact on ATSI health and is thought to

have exacerbated the high rates of family violence, including child sexual abuse now reported in ATSI communities (SNAICC 1991). Victorian Aboriginal women constituted 9% of those seeking refuge from domestic violence in 1993/4, which is highly disproportionate to their numbers in the population (Merlo, Foard et al. 1994). Abused ATSI women face even greater difficulties than NESB women seeking help, because of lack of trust in the police and legal system. ATSI communities have begun to tackle underlying issues for themselves (SNAICC 1991).

2.4.6 Hospital clinical studies

Victimised people are also found in hospital clinic populations. Two Australian hospital emergency department studies surveyed patients with self-report questionnaires, both using screening tools adapted from the CTS, and resulting in very similar rates. Roberts et al surveyed 1211 attendees at the Royal Brisbane Hospital accident and emergency clinic. They found an incidence rate of 7.4% among women and 2.7% among men, and a lifetime rate of 23.6% for women and 8.8% for men, although men were abused by both male and female partners. Being female and having been abused as a child was the highest risk for abuse as an adult. Most victims had attended a GP, although it was not reported whether patients had disclosed (Roberts, O'Toole et al. 1993).

De Vries Robbe et al (NSW) included NESB people in their survey. Of the 1169 respondents, they uncovered a lifetime partner abuse rate of 19.3% for women and 8.5% for men. Women physically abused were almost three times more likely than men to be sexually abused by partners as well. There were no significant differences between NESB and ESB people (de Vries Robbe, March et al. 1996).

Bates et al (Newcastle) interviewed 401 female emergency department patients with a more general tool, which resulted in a higher lifetime abuse rate of 25%. Consistent with the ABS survey, a high proportion of women (30%) reported abuse from a former partner (Bates, Redman et al. 1995).

Sherrard et al 1994 examined intentional injury and hospitalisation rates among victimised women and men, presenting to selected Victorian hospitals. Their data illustrate the limitations (inconsistency and inadequate documentation) in hospital emergency and admissions records. Within a limited definition, domestic violence cases totalled only 2% of cases presenting to the hospital emergency departments. The authors suggested that partner abuse victims in Australia were more likely to present to GPs compared with the US where victimisation rates in emergency clinics are much higher (Sherrard, Ozanne-Smith et al. 1994).

In summary, although the majority of victimised patients do not attend hospitals citing domestic violence as the cause, between a fifth and a quarter of all women (and 1 in 12 to13 men) who present to Australian hospital emergency departments have experienced one or more acts of

violence from an adult intimate partner. The most likely to be abused are women with a history of abuse in childhood. Victims are thought more likely to attend GPs than to go to hospital.

2.4.7 Pregnancy as a risk for abuse

GPs are common sources of antenatal care for pregnant women, offering opportunities to detect and intervene in partner abuse. Overseas studies have found varying rates of frequency and severity of abuse in pregnancy due to differences in samples and methods (Stewart and Cecutti 1993; O'Campo, Gielen et al. 1994; Naumann, Langford et al. 1999). The ABS population study found 42% of abused Australian women reported abuse during pregnancy (Australian Bureau of Statistics 1996). Abuse during pregnancy poses serious risks to both the mother and her baby (McFarlane, Parker et al. 1996 (a); McFarlane, Parker et al. 1996 (b); Wilson, Reid et al. 1996). It is four times more common among women with unwanted rather than wanted pregnancies (Gazmararian, Adams et al. 1995).

In the only Australian antenatal research to date, Webster's study of 1014 Queensland antenatal patients found that 29.7% reported a history of abuse. 5.8% had been abused during the overall pregnancy, however the rate increased to 8.6% at 36 weeks, indicating either that abuse commenced later in the pregnancy or that some abused women delay presenting until the final trimester. The prevalence of abuse was highest for those separated or divorced, although this may indicate that it was more difficult to disclose for those in a current relationship. 4.7% of women reported abuse in all categories of abuse (physical, sexual and emotional) indicating severe abuse. The more serious abuse was higher in secondary than tertiary educated women. The rate of abuse among the 103 pregnant teenagers was 43.7%, highlighting the risk to teenagers and their babies (Webster, Sweett et al. 1994).

McFarlane et al report that the more severe the abuse, the more likely women are to seek outside help (McFarlane, Soeken et al. 1997). They found that 17% of poor pregnant Texan women had been abused. Teenage mothers were more likely to report abuse not only from boyfriends, but other relatives as well. Abused women were twice as likely as non-abused women to defer prenatal care until the third trimester. They concluded that abuse during pregnancy is a comparable risk for low infant birth weight to being unmarried, having low weight gain, short inter-pregnancy interval and smoking. Abuse, they surmised, may compound the effects of conditions predating pregnancy such as smoking or substance abuse and catalyse others like anaemia and infections through forced avoidance of care. McFarlane and colleagues emphasised the importance of health service providers screening for abuse during pregnancy and having a good knowledge of community resources (McFarlane, Parker et al. 1992).

These studies draw attention to the health risks to pregnant women and their children (particularly young women and those with unwanted pregnancies) of intimate partner abuse.

2.4.8 Domestic violence and child abuse

GPs are also common sources of medical advice for parents and their children. In some Australian states, including Victoria, GPs are mandated to report child abuse. Since 1993 in Victoria, the Children and Young Person's Act 1989, section 64 (1A) mandates legally qualified medical practitioners and other professionals to notify child protection services if they believe:

'based on reasonable grounds, that a child is in need of protection because the child has suffered, or is likely to suffer, significant harm as a result of a physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from such harm' (Child Protection Victoria, 1993).

A 1996 Victorian booklet advised those mandated to notify authorities about the facts, signs and stages of intervention in child abuse but did not highlight the strong association between child abuse and domestic violence (Victorian Protective Services Program, 1996). A limited number of workshops offered advice to notifiers about their responsibilities and the support available to them.

In a critical literature review, Edleson found the overlap between women battering and child abuse varied according to the sources of data analysed, eg child maltreatment program data or refuge data. He estimated that in 32%-53% of all families where women were beaten, their children were victims of the same perpetrator (Edleson 1997). He also reviewed the problems associated with children witnessing domestic violence. In 31of the 84 studies he reviewed which met criteria for rigour, children who witnessed abuse could experience behavioural, emotional, cognitive and long-term developmental problems. Edleson cautions against being able to confidently conclude much about the problem, because of the many exposures to violence experienced by children, the limitations of measurement and lack of thorough research. These conclusions were reinforced by a recent critical overview of the problem (Fantuzzo and Mohr 1999). Edleson found that the long and short-term effects were influenced by whether children were also abused, child characteristics, the time since the event, and parent-child relationships (Edleson 1999). If abuse is not stopped and the victims properly supported, child abuse and witnessing partner abuse increases the chances of both adult victimisation and perpetration (Alexander, Moore et al. 1991). Men who are perpetrators may abuse both children or stepchildren and women are more likely to abuse children if they themselves are abused (Stark and Flitcraft 1994). Thus children in a family where partner abuse occurs are at risk from either parent.

The ABS study indicated that many (just under 50%) children are present when their mothers are being abused. Many other studies have reported similar prevalence (Goddard and Hiller 1993; Stark and Flitcraft 1994; Australian Bureau of Statistics 1996).

As mentioned above however, child abuse and domestic violence were identified separately, and services to detect and support adult and child victims have also developed separately (James 1994). While public awareness of both child abuse and domestic violence is higher than

previously, evidence for effective interventions in child or partner abuse is very poor. It is therefore difficult to educate health professionals effectively about how to intervene with children living with violence (Krugman 1995).

2.5 The health effects of abuse

Being subjected to domestic violence can lead women to alcohol and drug abuse and high rates of psychological or psychiatric illness, including suicide attempts (American Medical Association 1992). Abused women experience are also at greater risk of physical injury and death, gynaecological problems, complications in pregnancy and childbirth, depression, anxiety, chronic somatic disorders, STDs and HIV infections and eating disorders than other women, which can lead to the increased use of health services and resources (Eisenstat and Bancroft 1999).

Men who abuse have been found to drink at high-risk levels (Frances 1996). In clinical studies, abusive men have been shown to have elevated levels of drug and alcohol abuse and psychological disorders, including depression, psychopathology and suicidal ideation (Stuart and Holtzworth-Munroe 1995; Sugarman, Aldarondo et al. 1996). In advising doctors about men using violence, Mintz and Cornett suggest that stress, high blood pressure, digestive upsets, headaches and hand injuries may be common presenting problems of cyclically emotionally volatile men using violence (Mintz and Cornett 1997).

Exposure to violence between parents results in higher levels of physical and psychosomatic disorders, behavioural problems, post-traumatic stress and poor educational achievements in children and young people in both Australian and overseas studies (James 1994; Mathias, Mertin et al. 1995; McCloskey, Figueredo et al. 1995; Fantuzzo and Mohr 1999). Despite the limitations of the research to date, there is evidence that the children of victims are not only at risk of abuse, but those who witness violence suffer similar psychological and physical illness as children who are themselves abused (Fantuzzo and Mohr 1999). Barkan and Gary argue that the 'web of detection' of domestic violence should be expanded to include paediatric services, as empowering abused mothers will assist in protecting children (Barkan and Gary 1996).

2.6 Prevalence, identification and inquiry about partner abuse in general practice

It is clear that women experiencing violence and their children have graver health problems than the general population. Similar to studies overseas, the ABS survey found that if they talked to anyone, most women approached family and friends before anyone else. Only 12% of those physically or sexually assaulted spoke to their doctors about the abuse (Australian Bureau of Statistics 1996).

A major reason for the lack of disclosure appears to be that doctors do not ask their female patients about abuse (Hegarty 1996). In an Australian GP study (n=15 practices), Mazza found that over a quarter (28%) of 1500 female patients reported being victims of physical or emotional

abuse in the previous year, one in ten having experienced severe physical violence. Of the victimised women, 73% had never discussed this with a doctor. The majority (54%) stated that this was because they had never been asked. Mazza's results should be interpreted cautiously, as they may be biased by sampling error and the broad definition of abuse (Mazza, Dennerstein et al. 1996). The lack of inquiry has been found in other victimised patient studies (Hegarty 1996; Naumann, Langford et al. 1999).

In one US clinic, the addition of a direct abuse question to a self-administered questionnaire increased the disclosure rate from 0 to 11% (Freund, Bak et al. 1996). In comparison, McFarlane et al found that four times as many women disclosed their victimisation when asked directly by a nurse, than when they responded to questions on an intake form (McFarlane, Parker et al. 1992). Ninety eight percent of primary care patients in another study said they would like their doctors to ask them about abuse (Freund, Bak et al. 1996).

In California, Rodriguez et al surveyed 149 family doctors, 115 internists and 136 obstetricians/gynaecologists to investigate physician screening and intervention with partner abuse (Rodriguez, Bauer et al. 1999). 80% of family doctors stated that they often or always asked when patients had injuries, but only 10% asked a new patient and 9% during periodic checkups. Eleven percent of antenatal care providers were estimated to ask during the first patient visit. Screening was not significantly associated with GP sex, ethnicity, medical training, personal experience of abuse or knowledge of California's laws. However, doctors working in public clinics were significantly more likely than those working in other settings to screen on the patients' first visit. Three times as many doctors with recent domestic violence training (24%) reported screening antenatally than those without such training (8%). Rodriguez found that doctors believed patient barriers, eg patients' fears of retaliation and lack of disclosure, prevented them identifying and referring more often, as other studies also uncovered (Sugg and Inui 1992; Ferris 1994; Head and Taft 1995). Less than half the doctors identified lack of training, time, knowledge of referral agencies or beliefs that doctors cannot make a difference as major barriers. The authors conclude that doctors are not adhering to current guidelines for screening, which would improve important opportunities for early intervention. They also suggest that effective professional training required sustainability, structural changes and institutional policies (Rodriguez, Bauer et al. 1999).

The incidence rate for victimised women in US primary care patient populations has been estimated at between 12-29% and the lifetime prevalence 20-39% (Naumann, Langford et al. 1999). Many doctors believe that they identify a small proportion of victimised women in their patient populations (Ferris 1994). However, doctors may not be aware of what presentations are common in victimised women other than injuries. McCauley et al's 1995 family practitioner (FP) patient survey found a 5.5% incidence rate and a lifetime rate of 21.4% among 1,952 female respondents at four US primary care internal practices. Over a quarter (27%) of currently abused

women were abused more than four times and 49% were severely abused. In comparison with non-abused female patients, currently abused patients were:

- thirteen times more likely to have been abused as a child
- six times more likely to have a partner abusing drugs or alcohol
- four times more likely to be under 35;to be drug or alcohol addicted; to have attempted suicide or to be poor and
- twice as likely to be single, separated or divorced.

The probability of abuse increased proportionately to the numbers of risk factors present. Only 15.7% of abused patients reported discussing their abuse with a physician (McCauley, Kern et al. 1995).

The relationship between severity of abuse and GP inquiry has been investigated recently in Australia (Hegarty 1998). Using her newly developed comprehensive screening tool, the Composite Abuse Scale, Hegarty found that one in five (19.6%) women (n=1,836) in a random sample of Brisbane general practices (n=25) suffered some form of abuse in the last twelve months. Four percent of women suffered severe combined abuse (physical, sexual and emotional abuse/harassment). Almost five percent (4.9%) experienced physical abuse with emotional abuse or harassment. A similar number reported uni-dimensional abuse, ie 5% reported physical abuse alone and 5.4% emotional abuse and /or harassment.

Hegarty suggests that a full-time urban Australian GP sees at least one woman a week from each of these abuse categories (Hegarty 1998). While just over a third of abused women (36.7%) had told a GP at some point, 87.8% had never been asked about abuse by their GPs. GPs were significantly more likely to ask women who had experienced severe combined abuse. Compared with other abused female patients, women who experienced severe combined abuse were less likely to be in the paid workforce and more often separated or divorced. These women were more likely to present with children, to tell the GP and to have the GP inquire about abuse. They were also likely to have injuries and be more afraid of partners than women with other forms of abuse. Women who reported physical abuse only were less likely than severely abused women to disclose to GPs. Women experiencing abuse were more likely to attend practices with female GPs, those open for extended hours and either solo or a medium size (>3 GPs) (Hegarty 1998). Hegarty's findings about severity of abuse and inquiry echo that of a small US study (n=394 women) where researchers found only 19% of doctors had accurately recorded the disclosed abuse (Saunders, Hamberger et al. 1993). Other studies have found even lower documentation rates (Naumann, Langford et al. 1999).

Overall, whilst just over a quarter of female primary care patients have experienced some form of abuse in their lifetime, those with chronic and severe abuse are both more likely to disclose, and also to be asked by GPs. Family doctors are estimated to see at least five non-disclosing

victimised women a week. Victimised women are more likely to be young, to have children, be separated or divorced, pregnant or suffer from a drug or alcohol problem. However the number of GPs who inquire about abuse, where symptoms are other than injuries, is very low.

2.6.1 Men who abuse seeking help from general practitioners

Far less is known about the health problems and medical experiences of men who use violence than about their victims. Male patients who abuse their partners have only very recently been identified among family physician patient populations. In a unique but small US prevalence study (using an anonymous questionnaire survey of male patients in three family medicine clinics) 13.5% of men (n=237) attending, disclosed using violence towards their partner (4.2% using severe violence) in the previous twelve months. The data suggested that men who were depressed, alcohol abusers or who were childhood victims of abuse may abuse partners. The presence of stepchildren in the home was also a significant pointer to partner violence (Oriel and Fleming 1998). Over the past fifteen years, very few articles in the medical literature have discussed the possible role for family doctors in the identification and treatment of men who use violence, as part of an overall response to domestic violence (Oglov 1985; Searight 1997).

In 1985, Herbert (cited in Oglov, 1985) pointed out that family doctors may be the only professionals who see all members of the family. If abusive men are the friends or acquaintances of family doctors, particularly in rural areas, this may be a barrier to inquiry about abusive behaviour. When men do seek help, Oglov raised concern about GPs referring men to self-help groups. Men's groups are not always accessible and their outcomes poorly evaluated (Oglov 1985). Oglov's concerns echo a recent Australian unease about men's behaviour-change groups as unproblematic services to which other providers such as GPs could refer, as their effectiveness is still debated (Keys Young 1999).

Hacker, in a small non-random study of Melbourne male abusers, found his male study participants denied, minimised and justified their abusive actions, regardless of the level of their abuse. Men with restricted emotionality were unlikely to seek help, many men were unaware of where to find help and would resist help with 'emotional' problems, but could be challenged to make contact with providers and should then be rewarded for their courage in doing so (Hacker 1997).

Hamberger, a therapist/clinician who has worked with abusive men, outlined advice on identification strategies and described common characteristics of perpetrators to which GPs should be alert:

- a lack of assertive communications skills
- difficulty in negotiating interpersonal conflict
- minimisation and denial

- a history of drug and/or alcohol addiction
- possible personality disorder
- a history of violence in the family of origin
- frequent verbal arguments with spouse and/or
- excessive jealousy, overpossessiveness and intrusiveness.

(Hamberger, Feuerbach et al. 1990).

Mintz and Cornett offer advice to doctors about distinguishing between different types of men using violence:

1. **Cyclical emotionally volatile batterers** - The majority of these men experience a constellation of feelings, including rage and jealousy, and blame their female partners for their ill health and dependency. They commonly behave in the cycles of violence first described by Walker in 1979 (Walker 1979). At their wives' insistence they may seek treatment for stress, high blood pressure, digestive problems or headaches.
2. **Over controlled batterers** - These men use more psychological, rather than physical abuse. They are either active controllers, meticulous, perfectionist and domineering, or passive abusers who distance themselves, respond well to treatment and are conforming and obedient in public.
3. **Psychopathic batterers** - These men are described as lacking both emotional responsiveness and remorse and may be a danger to the doctor. They are generally violent to strangers, co-workers and friends. They often have criminal records.

They suggest that doctors need to be aware of these different types of batterers, because different men require different forms of treatment and referral. They suggest the doctor connect the male patient's presenting problem with his abuse and offer another consultation if he isn't ready to deal with it. They also suggest referral to group therapy where cognitive, behavioural or social learning approaches are used. Where any physical violence is present in the relationship, they strongly advise against couple counselling (Mintz and Cornett 1997).

In summary, GPs are seeing men who use violence. Men who abuse may present with both psychological and physical symptoms, but will commonly minimise their violence and may blame it on their female partners. Doctors may need to learn specific techniques for encouraging men's disclosure and acceptance of responsibility and to be able to discern the different types of men who abuse.

2.6.2 The 'dual relationship' - when both partners are patients of the same doctor

Ferris et al recently produced the first set of guidelines for physicians who see both partners in their practice (Ferris, Norton et al. 1997). Developed through a systematic process, the guidelines

note that primary care physicians are trained to remain neutral in family conflicts, but state that it is not a conflict of interest to deal actively with the issue with one or both partners. Contact should be made independently with either partner and doctors are urged not to consider their personal knowledge of the male patient in determining the risk to the woman. Doctors are advised that neither should such knowledge influence them to ignore reported abuse. If doctors feel uncomfortable with the dual responsibility or have personal experiences which may interfere, they should refer a patient to another doctor. Some members of the advisory committees disagreed about the appropriateness of initiating contact with a man (with his partner's permission) to specifically discuss the abuse, as they believed this required expert skill. The guidelines strongly advise against any marital counselling, unless the physician has specific training in partner violence therapy and specific mental disorders, (there is a high rate of mental illness amongst wife assaulters in overseas clinical men's groups). If counselling is undertaken, it should only be when the violence has ceased, as women's safety could be jeopardised. The remainder of the guidelines deal with more detailed issues related to identification and management of both partners (Ferris, Norton et al. 1997).

2.7 The experiences of women seeking help from general practitioners

Several recent Australian studies have identified women's responses from family doctors when they have disclosed, most finding room for improvement. Over a third of victimised female respondents in the Victorian phone-in found their doctors helpful, while a third did not and the remaining third made no comment (Women's Policy Coordination Unit 1985). In Queensland, 43% women spoke to their doctors about the abuse. Sixteen percent approached their doctors first. More women spoke to doctors than to any other person. In eight percent of cases, the doctor had helped them resolve their situation (Queensland Domestic Violence Taskforce 1988).

An Australian phenomenological study of 20 chronically, severely abused women explored their beliefs, expectations and experiences of GPs. Sixty-two percent of women said most GP responses to their disclosures were negative/unsupportive (Taft 1995; Head and Taft 1995). Male GPs responded more unsupportively (71%) than female (31.3%). NESB women experienced more negative responses from GPs of either sex. Many of the women believed that the GPs didn't care. In comparison, those few who reported positive experiences felt that this had been very important in altering their perceptions of themselves and in some cases transforming their lives. When asked the qualities of an ideal GP, the participants characterised empathic listening, supportive and non-judgmental GP qualities as important, combined with a sound knowledge of good referral services.

In a separate GP arm of this study, interviews were conducted with 27 GPs randomly selected from within a Victorian GP division (Head and Taft 1995). Female GPs spoke of seeing more women victims than their male counterparts, but they did not describe better management practices. However, similar to an American study, there was dissonance in the joint study between

women's expectations (that doctors should help them stop the abuse) and the doctors' perceptions that they were there to listen, support and discuss options (Bowker and Maurer 1987). The major barrier to better management of domestic violence by GPs was their lack of knowledge and confidence, which they attributed to a lack of training (Head and Taft 1995).

There are many barriers to women disclosing, which both female patients and doctors bring to the consultation. Common ones for women include: believing that it is their own problem, lack of money and alternative housing; normalising the abuse; threats from partners; shame or embarrassment; despair; fear of being judged or disbelieved; concern about confidentiality; beliefs that he will change or that his violence was her fault (Head and Taft 1995; Rodriguez, Quiroga et al. 1996; Hegarty 1998; Keys Young 1998).

Women identify many differing points at which they will seek help. These may include fearing for her physical safety, for the well-being of her children or other family members, the loss of hope about her partner's ability to change or her increased self esteem through study or work (Keys Young 1998). Gerbert et al likened the victim/provider relationship to a complicated dance of disclosure by victims and identification by providers. They suggest there may be good reasons why women are not ready to disclose and GPs should be sensitive to women's readiness. They argue that if doctors suspect abuse, they should condemn it, validate the victim's worth and decision-making. They do not recommend routine screening since women's range of situations 'defies any standardised or formulaic response', but the necessary qualities which doctors should possess are supportive styles and flexible and adaptive sensitivity to individual women's situations (Gerbert, Abercrombie et al. 1999).

The evidence clearly indicates that general practice populations contain many abused women who bring their health problems frequently to the doctor, often present with vague symptoms, but are rarely asked about abuse and mostly do not disclose because of many barriers, including fear, shame and depression. Similarly, GPs are not trained to recognise symptoms, not confident or knowledgeable about the most effective action to take, when women do disclose. Validation and supportive, non-judgmental but informed styles of GP consulting are those which women report as most helpful. There has been no similar research into the experiences with GPs of men using violence.

2.8 Domestic violence and the medical profession

Domestic violence is a complex social problem requiring clinicians to step outside the traditional biomedical paradigm to confront personal feelings and social beliefs shaping their attitudes to patients. Clinicians' own responses can be filtered through the range of socialised beliefs, including those of gender, race and class within which their own identities are constructed. Listening to women describe the violence in their lives can have a significant, possibly traumatic impact on clinicians themselves, for which they may not be prepared. The professional

socialisation of medicine may itself 'serve as a vehicle for the inter-generational transmission of abuse' (Warshaw 1996). The medicalisation of social problems can fragment the complexity of interrelated problems associated with abuse. Victims may then be re-traumatised by the disempowering actions and attitudes of medical professionals. Medical institutions themselves can structurally inhibit effective practice, which requires clinicians to work in collaborative partnerships with community groups committed to ending domestic violence. Domestic violence challenges medicine's theoretical models, the nature of medical training and the structures of clinical practice (Warshaw 1996).

As early as 1979, Pahl related the Royal College of General Practice UK's definition of a GP to expectations that untrained GPs would be seeing abused women. After researching battered women's experiences of GPs, Pahl concluded:

> *Whether marital violence is explained in terms of the individual, or the family, or in terms of broader social patterns of inequality, must affect the way in which the general practitioner approaches the problem. Similarly, whether the general practitioner defines his or her role narrowly or broadly must affect the nature of the help which is offered. Is the doctor responsible for the bruises or for the patient?' (Pahl 1979 p.122).*

Advice to family practitioners reflected diverse and sometimes contradictory views about how GPs should manage domestic violence. Early advice in medical journals to family doctors differed, depending on whether family violence (partner and child abuse, incest and elder abuse) or wife battering was the focus. The emphasis in advice was greatly directed to identifying victims, helping patients acknowledge their family problems and referring (mostly to crisis services), although Herbert cautioned against insisting on marital therapy in cases of wife battering without the victim's consent (Pelton 1982; Herbert 1983).

Prior to the rising awareness of domestic violence, McWhinney, an influential family medicine educator, discussed a new agenda for family medicine education in 1975. In describing a family-centred approach to family medicine, he wrote about how a family doctor gained in knowledge and scope of action when shifting focus between the family and the individual patient and when considering any impact of management decisions on the family (McWhinney 1975). Later, in his classic family medicine textbook, although he outlines the challenges of family practice in great depth, he does not explore the implications or problems of a family-centred approach when confronted with family violence. He focuses on the destructive impact of poor mothering on children and does not consider the possibility of partner abuse in this context. In the small sections on family conflict and violence, he argues for a stance of neutrality and provides no further guidance about domestic violence nor recommends support services (McWhinney 1989).

Murtagh, in his Australian family medicine textbook, offers some contradictory advice to clinicians about family practice and domestic violence both in content and the book's structure

(Murtagh 1994). The chapter on domestic violence advises against couple counselling, however other sections on family counselling and marital therapy do not integrate this advice. The two chapters on child abuse and pregnancy do not mention the possibility of domestic violence nor any consequent management advice about it.

Early in her work, Candib suggested that while there was agreement in family medicine about family problems, there was a great deal of confusion about the skills a family doctor requires to deal with them, particularly with differing theoretical models of family therapy and family intervention strategies (Candib 1985). She challenged the notion of neutrality, arguing that instead, GPs' projection of roles which stereotype women/mothers and men/fathers may contribute to exacerbate already problematic family dynamics. 'We must learn to see how our everyday work with patients assumes and promotes certain family constellations which may be creating symptoms in the first place'. She cautions doctors about the 'alliances created by their gender' (p206), suggesting this can be the result of empathic behaviour of doctors of either sex, but in differently gendered ways.

In her 1995 family medicine textbook, Candib extends her thesis on the problems with family medicine to violence against women (Candib 1995).

> *'Medicine operates under the impression that its theory and practice are gender neutral. But women, both clinicians and patients, are only too aware that that the practice of medicine is gendered in a masculine way' (pxi).*

Medicine takes a strong ideological position of opposition to the objectification of patients and seeing symptoms out of context, but is ill at ease with focussing on problems associated with gender. Candib identifies problems for GPs of 'taking sides' and alienating men, for fear of losing both partners from a practice population or confronting their own or family of origin experiences. She also argues that for doctors to confront gender issues in families may imply radical attitudes and the need to rethink the family as the preferred environment in which to live and raise children. Family medicine derived from family systems theory, which implies relations between partners as equals. The fallacy of equivalency enables family physicians to avoid the complex and troublesome issue of responsibility for violence and how to overcome it (Candib 1995).

2.9 Doctors responses to dealing with domestic violence

Doctors experience many barriers to detecting and managing abuse. These can include that they:

- do not recognise non-physical symptoms
- experience close identification with patients
- experienced violence themselves as victims or abusers
- fear offending patients
- do not know how common domestic violence is
- believe if they do not see it, it is not a problem, so do not ask
- do not have the time
- do not understand the consequences
- do not believe that the man could be an abuser
- feel powerless
- are ignorant of community domestic violence agencies
- and in the case of some male GPs, think that their gender is a barrier

(Ferris and Tudiver 1992; Sugg and Inui 1992; Brown, Lent et al. 1993; Ferris 1994).

Despite the existence of barriers, health care providers are advised that they can help or hinder women's recovery from intimate partner abuse (Heise, Ellsberg et al. 1999). In a 1995 Australian study, a consensus in the literature around good practice with female victims of domestic violence was identified. Doctors should:

1. Uncover abuse early by asking directly about it
2. Assess the safety of women and children (if necessary develop a safety plan)
3. Examine and carefully document her health problems and injuries
4. Give information about violence and tell her that it is not her fault
5. Have knowledge of support agencies, inform her and explore her options
6. Support her decisions (Head and Taft 1995).

Most current advice is still consistent with these recommendations, with the addition of recommending perpetrators to men's groups and not counselling couples (Kynaston 1995; Hindmarsh 1997). Heise illustrates two contrasting models of medical responses, adapted from the Duluth Power and Control 'wheels' of partner abuse. These models suggest that doctors can either mirror the control which a patient experiences from her abusive partner or transform it (Heise, Ellsberg et al. 1999). Figure 2 illustrates inferior practice.

Figure 2: Contra-indicated practice with victimised women

The second model, Figure 3 below, is transformatory. It emphasises maintaining confidentiality, calls attention to safety and respectful and supportive behaviour.

Figure 3: Recommended practice with victimised women

However, obstacles preventing doctors working effectively extend beyond those experienced by the individual practitioner. Investigators recently studied five major US cities to analyse impediments to physicians identifying and managing violence in families. They found that:

- despite each city's health institutions recognising the seriousness of the problem, there were no overall management responses
- existing programs were driven by charismatic leaders who developed and drove programs, which withered after they left
- health service providers who worked consistently with the problems reported being marginalised by colleagues and facing serious economic, social and psychological disincentives to family violence work
- access to the health care system overall was inadequate for those from lower socio-economic groups
- although still inadequate, the child abuse system was the best developed having arisen from within the health care system, but the health services were reluctant partners in violence against women, because change for battered women had been initiated by the women's movement
- there was little effective coordination among agencies responsible for addressing family violence and
- primary prevention of family violence was only addressed by advocacy groups (Cohen, De Vos et al. 1997).

Despite these barriers, recent studies have indicated a growing willingness among medical practitioners to consider that uncovering and managing partner abuse is part of their role, but less actual practice than belief. Friedman et al surveyed 164 patients (64% women) and 27 physicians about routine questioning for physical and sexual assault. He found that patients wanted doctors to ask routinely about physical and sexual assault, but were rarely asked, whereas doctors felt they could help with such problems but frequently do not inquire. Patients believed that doctors could help with these problems (Friedman, Samet et al. 1992).

A Canadian national family practitioner (FP) survey (n=963, response rate 63%) found that doctors believed 15% or more of their women patients suffered domestic violence, but that they identified only a third of the victims (Ferris 1994). Over two thirds did not believe they could diagnose abuse effectively. Whilst they overwhelmingly believed that they ought to identify abuse, 68% GPs had no standard method to detect it. Those doctors who did were more likely to identify it. They ascribed responsibility for their low rate of detection much more on the barriers to disclosure the abused women experience, rather than any they themselves brought to the consultation. Most believed GPs should either make referrals or counsel victims themselves. Women doctors did not differ in detection rates, but they differed in their treatment options, not endorsing marital counselling, which was contra-indicated, or talking to the abuser, (as males did), but providing emotional support and referrals. Younger FPs were more likely to refer women to

refuges, while older FPs referred to lawyers. 87% of responding doctors said they wanted more continuing medical education on this topic.

More recently, Ferris and her colleagues uncovered notable patterns in FPs' actual management practice in a national random study limited by its 51% response rate (n=2014 FPs). Using 16 variable case scenarios, Ferris et al identified:

- A group of doctors who would ignore the issue whether women disclosed or not
- A group who act from passively to pro-actively only when a woman acknowledges abuse
- A group who would take action whether or not the woman acknowledges victimisation.

Some actions were limited to giving information or talking to the abuser about stress or his relationship. Older male FPs were more likely to hold conservative views about the issue, talk to the abuser whether the doctor/male patient relationship was good or not and to endorse contra-indicated practices, such as couple counselling. Most importantly, the study sounded caution that the family practitioner's 'dual relationship' with the couple more often determined the doctor's choice of management plan irrespective of the severity of the abuse or the emotional consequences (Ferris, Norton et al. 1999).

In Australia the Easteals' GP study (n=96), limited by a response rate of 50%, found that older doctors held more conservative views about the causes of domestic violence and the doctor's role in intervention. Female GPs held more liberal beliefs than male doctors about causes and interventions. Doctors had little training about the issues and while believing they had a role, were reluctant to act (Easteal and Easteal 1992).

Other studies also indicate that GP characteristics, such as age and gender may be important in the ways GPs respond. In a small US study, Saunders compared the impact of two hours of training in the identification and management of woman abuse provided to 17 family practitioners (FPs) with 22 untrained controls. He used standardised woman abuse patients to evaluate the training, and found that female FPs provided better care to abused women whether they were trained or not. Training had no impact on any outcome variable (Saunders and Phillips Kindy Jr 1993).

These findings suggest that while many doctors believe they should be doing more for abused patients, most do not because of structural and attitudinal barriers. There may be consistent differences between groups of doctors in their willingness to engage with the issue and when they do, their responses may be guided more by their relationships with both partners than the severity of the abuse. There is some evidence for patterns of gendered practice.

2.10 The feminisation of general practice

In Australia as overseas, a higher proportion of female than male medical graduates, are choosing general practice. It is predicted that by 2007, 50% of non-specialist medical practitioners in

Australia will be women (GP Branch 1996). There is considerable debate about how sex differences might impact on practice in general and partner abuse management in particular.

In addition to sex distinctions found by Ferris and her colleagues, a randomised stratified study of 720 Canadian medical practitioners, found that female practitioners held more positive attitudes to psychosocial practice, patient education and health counselling. The study may have been confounded by sample bias (Maheux, Dufort et al. 1990). Both in Sweden and Australia, female GPs have been found to have longer consultation times and to manage different problems, in particular, more female-specific and psychosocial issues (Bensing, Van Den Brink-Muinen et al. 1993; Britt, Bhasale et al. 1996). One might therefore assume that female practitioners would be more likely to see both women and men living with violence. There are many similarities, but also important differences between the sexes eg in doctor-patient communication styles, which can have an impact on management of domestic violence. Women have been found to be more egalitarian in style and make less effort to maintain control over the patient. Patients talk more with women doctors who talk more than males, particularly in history taking (Martin, Arnold et al. 1988). Such a style is likely to be beneficial to disclosure and history-taking with women experiencing abuse. Candib, when discussing gender barriers to effective partner abuse medical practice, added that male doctors feel uncomfortable as they may feel implicated in partner abuse, while female doctors are taught to protect others' feelings and may also feel uncomfortable (Candib 1995).

However, the evidence of GP sex differences is equivocal, as some studies do not find these differences in practice (Head and Taft 1995; Rodriguez, Bauer et al. 1999).

2.11 GPs and stress

The past twenty years has seen a rising number of studies and growing concern over doctors' levels of stress. Sinclair argued that stress and depression in doctors is not an occupational hazard but a professional probability as a result of tensions between the individual and the rigours of medical training (Sinclair 1997). Concern about doctors' stress has been associated with the high rates of physician suicide in comparison with those in the wider community. When examining sources of doctors' stress in 1979, Mawardi found that GPs described lower job satisfaction than their medical colleagues (Mawardi 1979). Australian GPs, similar to those in Britain, have reported stress in the recent context of change and uncertainty about shifting roles and GP infrastructure (Douglas and Saltman 1991; Baillie, Sibthorpe et al. 1998). In a study of 408 British GPs, male GPs expressed more unhappiness than female GPs with the number of patients they saw with psychosocial problems (Branthwaite and Ross 1988). In a recent Australian study of GP stress, GPs identified that not being skilled in family or relationship issues was a source of stress, as were patients who presented frequently with non-specific symptoms. Doctors worried about time spent with patients, losing money with long consultations and seeing too many 'counselling' type cases (Winefield, Murrell et al. 1994). Patients with domestic violence may contribute

considerable stress to GPs in an already stressful environment, as they present often with non-specific symptoms requiring expert counselling.

2.12 GP counselling and domestic violence

There are no evaluations of GP interventions in domestic violence to guide evidence-based practice, nor is there much information to assist doctors to assess whether women have made a good recovery. Can a woman leaving a violent partner always be considered a good outcome, when she may then go on to find another? Is the absence of the symptoms with which she first saw the doctor a good outcome? Herman argues persuasively that victimised women, particularly those who suffered childhood abuse, have been poorly understood and diagnosed for many years and that they are better conceived as suffering from trauma. Those who experience prolonged abuse may suffer 'complex post-traumatic stress disorder' (Herman 1992).

Harvey's ecological treatment model for post-traumatic stress disorder identifies treatment outcomes to assess recovery from sequelae of serious abuse. The integration of the many factors in a patient's recovery requires a sensitive and careful history-taking, listening attentively to details about the woman herself, the damaging events in her relationship and her social, political and cultural environment. It further implies good skills in 'active listening', counselling, knowledge of effective referral agencies and an understanding of the patient's wider social/emotional support networks and material resources. The meanings patients attach to themselves, the events they experienced and how these will be interpreted in the wider multicultural community demands an even greater sensitivity on the part of the clinician (Harvey 1996).

In England, the Balints pioneered therapeutic counselling for GPs dealing with the underlying psychosocial issues for their patients (Balint and Norell 1989). British GPs do not always counsel patients themselves but increasingly, can refer within their multi-disciplinary clinics to trained psychologists. In a recent evaluation of counselling provided by psychologists and GPs in British general practices, most patients believed that professional counselling had helped them (Corney 1992). There was evidence (although limited) of a reduction in medical use, psychotropic drugs and psychiatric referrals. There was also limited evidence that GPs could be just as effective offering support rather than drugs, although more seriously affected patients would always need greater help and GPs may not have the time. A meta-analysis of 11 British studies of GP counselling compared with mental health professionals found the latter to be 10% more effective compared to GPs in counselling for social and behavioural functioning (Balestri, Williams and Wilkinson, cited in (Corney 1992). Corney concluded that GPs have a role in counselling patients but should refer those with greatest need to mental health professionals (Corney 1992).

Consultants, People Care Australia (PCA) reviewed the evidence for counselling effectiveness to assist in the purchasing of counselling services in the Victorian primary health care system (People Care Australia (1997). They argued that there was ample scientific evidence for the

effectiveness of differing forms of counselling. There was a growing body of professional competencies underpinning accreditation and the maintenance of counselling standards in the US and UK. PCA point out that professional counsellors are now working in a third of all, and 65% of fund-holding, general practices in the UK. The authors note an increased interest in GP counselling in Australia with some practices employing psychologists and a pilot project where GPs have undertaken extra training in order to be eligible for Medicare counselling rebates.

PCA argue for a general taxonomy of counselling:

(1) counselling only (reflection, constructive confrontation and problem solving for patients with adequate personal resources)

(2) counselling - therapy (recognised forms of therapy such as cognitive behavioural therapy for patients with less adequate resources)

(3) counselling casework (counselling or therapy with additional casework such as advocacy, service coordination and other forms of practical assistance).

With competency standards, they suggest this taxonomy will assist in distinguishing which form of counselling is appropriate for different clients. The final framework for counselling recommends counselling casework for those who work with victims and perpetrators of domestic violence, from brief to long term interventions, with staff requiring professional qualifications, counselling casework skills and additional specialist skills in domestic violence work. Recognised best practice in family violence, they argue, is a multi-disciplinary, multi-agency, coordinated network or integrated approach (People Care Australia (1997).

However, counselling competencies with men who abuse which allow them to disclose violence and accept responsibility for change are radically different from conventional therapies and for those which encourage women to disclose or which empower them to make positive changes (Hamberger, Feuerbach et al. 1990). This requires specific training acknowledging gendered positions, personal attitudes (including avoiding the temptation to be a 'rescuer') and personal or family experience. It also includes strategies for minimising practitioner stress, as counsellors require debriefing and support to sustain themselves during such demanding work (Younger 1997; Pogue 1998).

Thus, the literature indicates that GPs can provide some forms of counselling for patients with less serious psychosocial problems. In the UK, there is evidence that this level of GP counselling results in consumer satisfaction and reduced medication use. It also suggests, however, that victimised female patients may be suffering forms of post-traumatic stress disorder and, together with male patients who abuse, they require more complex professional counselling strategies. Present evidence suggests GPs do not have adequate counselling competencies, support or infrastructure to effectively counsel such patients and that they suffer considerable stress as a consequence.

2.13 Medical education on domestic violence

Over the last five years there have been major advances in health service provider curricula and guidelines development around domestic violence, particularly in the US and Canada. In 1992, the American Medical Association (AMA) and the US Surgeon General declared that there was an epidemic of violence and publicly announced that it was a priority public health issue. A 1992 edition of the Journal of the American Medical Association carried the AMA's statement and articles on this issue. The AMA's Council on Scientific Affairs and Council on Ethical and Judicial Affairs published three major position papers - Violence Against Women: Relevance for Medical Practitioners; Diagnostic and Treatment Guidelines on Domestic Violence and Physicians; and Domestic Violence-Ethical Considerations (American Medical Association 1992; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992).

Many handbooks and curricula for medical students and guidelines for doctors in family practice and other specialties have been published (Sassetti 1993; Alpert 1995; Hoff and Ross 1995; Ambuel 1996). In 1995, the American Association of Medical Colleges (AAMC) published the results of a consensus conference on the teaching of family violence followed by a 1997 supplement outlining their curriculum recommendations, educational research and evaluation (Kassebaum 1995; Brandt Jr 1997). In Canada, there have been similar governmental, provincial and medical association responses (Committee on Wife Assault 1990; Hoff and Ross 1995).

2.13.1 American curricula in family violence

The US medical colleges have proposed a vertically integrated curriculum on family violence, ie consolidating learning at each incremental level of professional training (Alpert 1997). Medical educators considered how abuse education should progress over the stages of a doctor's learning career. Attitudes are a major emphasis at all levels of the proposed American family violence curriculum as a result of the US research which found that providers' prejudicial opinions seriously compromised victims' care and the capacity of the health system to respond to family violence. US research has also highlighted the lack of coordination among family violence agencies (Cohen, De Vos et al. 1997).

The proposed core curriculum for US medical under-graduate students emphasises not only developing appropriate attitudes, but also an appreciation of cross-cultural differences, manifestations of abuse in different classes and the consciousness of barriers which doctors themselves may bring to the consultation. It includes empathy for victims' own barriers and the need for collaborative teamwork (Alpert 1997).

Graduates are expected to have developed a sense of urgency about the issue, respect, empathy and concern for the victim, cultural awareness and a capacity for collaboration. Postgraduate goals stress the strengthening of appropriate attitudes, knowledge and skills necessary for comprehensive long-term care of victims and target primary care and certain medical specialties,

such as obstetrics/gynaecology. They also include exploring both the professional and personal barriers to effective care of victims, legal issues and identifying those who may become lecturers and researchers in the area. Brandt et al add that at this level, study should include abuse aetiologies, relationships between family violence, substance abuse and mental illness and include ethical dilemmas which 'may arise when treating multiple members of a family'. A further curriculum for professionals who wish to specialise in the field is available (Brandt Jr 1997).

In a special supplement of Academic Medicine devoted to the teaching of family violence, it was argued that students need to learn in an environment in which they can address complex issues and the difficult feelings which learning about abuse may raise (Warshaw 1997). A sensitive teaching process requires teachers who can model non-abusive behaviours and teaching institutions, which support such an environment in their practices. A recommended advocacy management model is one developed through collaboration between community advocates and health service providers. In such a model, practice principles include: prevention; safety; empowerment; advocacy; accountability and social change. Doctors would need to appreciate the individual and societal forces which generate and sustain abuse; the contextual factors which mediate patients' experiences of abuse and shape their options; individual and systemic factors which shape providers' responses. Any course, it is argued, should recognise the consultation's potential to re-traumatise victims and traumatise clinicians themselves (Warshaw 1997).

Most of the recommended curricula in this supplement recognise the central importance of values and seek to develop strategies, which both teach and evaluate attitudinal change. An evaluation of one such course trialed at U.C.L.A. medical school is profiled in the supplement (Short, David et al. 1997). It found that the expertise and preparedness of teachers was vital to the success of the programs and required teachers to be aware of and sensitive to their own attitudes. The training and evaluation exercise most valued by both tutors and students incorporated a standardised patient, with whom students practised their consultation and from whom they received feedback. The evaluation study found that students developed a sense of urgency about the need to intervene but not an understanding about victims' dilemmas. Evaluators expressed concern about the importance of doctors' sensitivity to the needs and readiness for change of the victim. Doctors who believed they should intervene could act inappropriately, if they were insensitive to the woman's degree of readiness (Short, David et al. 1997).

2.13.2 Australian medical curricula and general practice

Australia experiences several difficulties in the training of general practitioners. Overall, the medical education system is not yet comprehensively vertically integrated. Australian GP training curriculum and practice has recently been reviewed. The review team argued that until recently, undergraduate medical education has had very little focus on general practice. In vocational registration, they were concerned that registrars had to generate income and therefore focussed more on service-delivery than education, and their practising GP trainers had been inadequately

paid or supported in their training. In general, Continuing Medical Education (CME) had been dominated by specialists and drug companies (Review of General Practice Training Group 1998). The Australian government is now responding to the review's recommendations for strengthening GP education and to changes in the GP educational environment such as the feminisation of the medical student population, more mature age student entry and the strong desire to respond to rural and indigenous health needs.

2.13.3 Undergraduate medical training about domestic violence

A specific national curriculum on family violence for Australian undergraduate medical colleges does not exist and there is an increasing emphasis on graduate level entry. Over the last few years, undergraduate medical schools in Victoria have offered a few hours condensed teaching on partner abuse within the five or six years of medical education (Hegarty, personal communication).

2.13.4 Australian postgraduate vocational curriculum and domestic violence

A 1993 Commonwealth government study of postgraduate medical training on violence against women noted that the vocational RACGP Family Medicine Program (now the RACGP Training Program) training differed greatly in each state (Tomaszewski and Ollie 1993). The authors expressed concern about aspects of the training program, such as the limited time, lack of focus on the criminality of domestic assault against women and how violence impacted on victims. Within the context of recommended training principles and standards, they argued for a national core curriculum, which in addition to including the criminality of assault and relevant legislation, comprised gender and power issues, attitudinal change and empowerment strategies. The authors argued for a train-the-trainer program with accredited trainers, resources and competency based standards (Tomaszewski and Ollie 1993). Five years later, a national audit of crime prevention training, which included health services and domestic violence, noted the lack of systematic and formal training of competencies around domestic violence (National Campaign Against Violence and Crime Unit 1998).

Vocationally, the role and training of Australian general practice have been redefined in the context of the Commonwealth general practice strategy review (General Practice Strategy Review Group 1998; Review of General Practice Training Group 1998). Reflecting changes relevant to vocational registration, the RACGP recently published the second edition of its training program curriculum, outlining 'exactly what was expected of Australia's future GPs'. The curriculum framework and its companion volume 'Making Sense of GP Learning' are intended as resources for GP registrars and their supervisors, teachers and mentors (RACGP Training Program 1999 a; RACGP Training Program 1999 b).

The curriculum framework has been conceptualised in a manner, which both explicitly and implicitly includes the some of the attitudes, knowledge and skills important for managing intimate partner abuse.

The framework consists of three major areas:

1. Domains of general practice;
    - Communication skills and the patient/doctor relationship
    - Applied professional knowledge and skills
    - Population health and the context of general practice
    - Professional and ethical role
    - Organisational and legal dimensions
2. Common and significant patient presentations; and
3. National health needs and priorities.

It stresses critical self-reflection and encourages discussion on value clarification. Several 'curriculum statements' or priority learning areas are pertinent to partner abuse, eg Children and Young People's Health, Ethnic Health, Men's Health, Women's Health, Practice Management and Mental Health. Each of these areas defines specific objectives in relation to the five domains of general practice. The vocational program offers three key learning approaches for the registrar GP.

- Experiential learning - 'on-the-job' training under the guidance of an experienced GP
- Self-directed learning
- Education release activities

In each of the special curriculum areas, placements and visits to community organisations, which target women, men and ethnic communities are suggested. For women's and ethnic health courses, 'experts' and/or speakers from the services are recommended. Role-plays for women and men's health, case presentations for men, children and young people, panel discussions and small group-work are also recommended.

The framework includes specific content on domestic violence and other forms of abuse in families. Despite an emphasis on GPs' attitudes and the integration of other forms of violence in the family, the content outlined does not include reference to gender and power, couples, men who use violence or children (RACGP Training Program 1999a). General teaching and learning approaches and aspects of assessment and examination are also included in the overall framework. However, as recognised in 1993, without a train-the-trainer program, the paucity of training for existing general practitioners makes it unclear as to who is qualified to teach the domestic violence curriculum effectively.

2.13.5 The RACGP Women and Violence Training Project

In 1993, the Royal Australian College of General Practice (RACGP) National Women's Health Project received federal National Women's Health Program funding to develop training programs for GPs about adult survivors of child abuse, sexual assault, domestic violence and elder abuse (Women and Violence Project RACGP 1998). The Women and Violence Project (WAVP) one-day train-the-trainer scheme prepares GPs to provide other GPs in their own division with two hours of training to support women victims of the many forms of violence.

The pro-feminist training curriculum addresses domestic violence, sexual assault and adult sequelae of childhood sexual abuse. The course has an accompanying manual covering adult survivors of childhood sexual abuse, sexual assault, elder abuse and domestic violence. It outlines the epidemiology of violence against women, sequelae and presentations. It seeks to dispel myths around the issues and presents case studies and management recommendations on each topic area. The second edition (1998) adds a section on perpetrators of all these offences, briefly describing the most common types of men who abuse, but GP management strategies for men are minimal, as this is not part of the brief. There are comprehensive sections on the law and the victim's stages of change. The manual does not specifically address cross-cultural issues, with the exception of one case study, nor yet include practical and ethical problems with couples (Women and Violence Project RACGP 1998).

In 1993, the overall aim of the innovatory two-hour teaching sessions offered by the project, was to explore victimised female patient presentations and management in general practice.

The specific aims were to:

- increase the awareness of the incidence of violence against women
- explore strategies for asking about a history of violence
- provide participants with an opportunity to experience different options for helping women in this situation eg helpful advice versus no investment
- provide information on how to take a good history of violence
- provide participants with an opportunity to explore responses to difficult statements
- present the model of stages of change
- present the cycle of violence
- refer to and elaborate on the manual

The project conducted eleven volunteer participant education groups (n=88 GPs) around Australia. They recruited two control groups (57 and 63 GPs). GPs in all three groups had expressed an interest in violence against women, with one group of volunteer controls forming

focus groups for the training module's development and the other recruited at an RACGP annual conference.

The manual and some articles were sent to education group GPs as pre-reading. The training sessions combined brainstorming, (eg around obvious and not-so-obvious presentations), role-plays and didactic teaching. Asking directly, having a trusting relationship, a high index of suspicion and posters signalling doctors' willingness to discuss the issue were taught. The teachers emphasised safety; listening, hearing and believing; reinforcing that violence was not her fault; that violence was unacceptable and that the woman remained in control of the consultation. The cycle of violence and stages of change were taught didactically and brief role-plays contrasted an expert versus an empowering stance. GPs were provided with the manual. Posters and leaflets addressing violence against women were on display.

Although the session's purpose was to address violence against women, in their evaluation report, the authors commented that many participant GPs wanted to look at issues for men also, as they argued that men constituted about half their patient population.

The evaluation of this first training project sent both education and control groups a pre- and post-training questionnaire (two months later) requesting their self-reported current cases of abuse, knowledge, attitudes, identification and management practices and use of referral agencies. Prior to training, participant GPs identified less than one case of domestic violence in a month. Although they believed that asking directly was the better practice, most GPs relied on self-disclosure by the patient for identification both for sexual assault and domestic violence. At baseline, 70% of GPs agreed that 'the best advice to offer women in domestic violence situations should always be to leave'. Thirty seven percent of GPs either agreed or didn't know if 'all incidents where men are violent toward women involved alcohol'.

The evaluation found that participant GPs' knowledge of prevalence and certain factors was high. GPs in the educational group showed a significant increase in their knowledge of referral resources, but a trend to only slightly higher identification rates. However, the rates were only measured over one month, which was unlikely to be enough time to detect any sustained or significant change. The evaluators commented on inadequate attitudinal changes and that:

> *GPs may require much more than a 2 hour session to change their response to questions, which may be a part of their individual belief system, rather than something learned previously from coursework or texts...Perhaps changes in attitudes, confidence and motivation are required to elicit changes in behaviour, even in GPs who have substantial pre-existing knowledge of the topic area.*

The evaluators discussed the difficulty of assessing answers about the management of complex abuse cases, which often have unique circumstances. They suggested that GPs need a greater number of flexible strategies, so that they can adapt their responses. If evaluation responses

elicited an increased repertoire of management options, rather than simply right or wrong, this would be a better indication of the training intervention's effectiveness (Royal Australian College of General Practitioners 1994).

By 1996 the college training program around Australia had trained a core group of 80 GP educators (49 women and 33 men). These GPs have conducted 27 further two-hour training groups (104 women and 88 men). The project reported that some of the GPs had no previous experience of peer education and limited skills in running groups. Within divisions, the project encountered barriers to GP recruitment from competition with other GP CME, and perceptions that violence is a difficult issue. Additionally, as some GPs were unsure of their counselling skills, they didn't like to ask their patients about violence (Women and Violence Project RACGP 1996). The WAVP funding ceased in 1997, however the RACGP provides some limited funding for the coordinator in this and all other GP-related women's health issues.

Most Australian CME domestic violence units last approximately two hours. Warshaw advises that it is important to allow clinicians the time to acquire the necessary interviewing skills and opportunities to address attitudes and feelings, which may inhibit appropriate care. One-off training may raise awareness, she advises, but ongoing feedback and support are necessary to sustain provider responses. Institutional support, together with collaborative networks, is necessary to sustain both patients and providers (Warshaw 1996).

2.14 Evaluation of Continuing Medical Education

There have been considerable advances in adult learning and major debate about the efficacy of Continuing Medical Education methods (Merriam 1996). Both GP CME domestic violence training and its evaluation are new and developing areas. Advances in the evaluation of continuing education argue for the inclusion of qualitative strategies in a 'mixed economy of methods', evaluating all stakeholder perspectives, including critical reflection and the contributions of feminist pedagogy and transformational learning (Al-Shehri, Stanley et al. 1994; Pitts, Percy et al. 1995; Merriam 1996). Haynes defined the purpose of continuing medical education 'to improve physician knowledge and performance and therefore improve patient outcomes.' Of 284 CME evaluation studies he reviewed, he found only three which attempted to evaluate patient outcomes, one which demonstrated effectiveness and, due to the period reviewed, none which were concerned with domestic violence (Haynes, Davis et al. 1984).

Any advances in the US and Canada have been linked to accreditation processes and the limits on physician performance evaluation have been acknowledged. Most evaluation has focussed on self-assessment processes (Escovitz and Davis 1990). Tracey et al found poor correlations between GPs self-assessment and their actual knowledge. They concluded that GPs were poor judges of their educational needs, although others argue that as general practice was too vast to keep up to

date, it was more important for doctors to be able to access necessary information promptly (Tracey, Arroll et al. 1997; Edwards, Robling Matthews et al. 1998).

The evaluation focus to date in Australia has been on GP satisfaction with training and self reported changes in knowledge, attitudes and behaviour, however support for improved evaluation methods is rapidly developing through the efforts of the Education Support and Evaluation Research Unit of the federal General Practice Program (Education Support and Evaluation Resource Unit 1997).

2.15 Summary

Intimate partner abuse is more prevalent in Australian GP patient populations than in the general community and has a serious impact on the health of all family members. Australian public health and other government policies have recognised that domestic violence is a serious health issue. While there are published management principles for doctors outlining strategies for working with victims, there is little research informing good management practice and victim feedback about general practice suggests that GPs have not yet acquired competencies to detect and manage the problem. However, they believe it is a professional responsibility. There is even less professional guidance about working with men who abuse and with children. Many studies have documented the structural and attitudinal barriers preventing doctors practising effectively. In addition it appears that the field of family medicine may itself require some rethinking to fully encompass the demands of family practice with family violence.

With little under- or postgraduate education on domestic violence in Australia on which to build, CME training on domestic violence in Australia was pioneered by the RACGP's Women and Violence Project, focussing on support for female victims. Domestic violence CME is evolving and strengthening, but has yet to incorporate recommendations about the need for attitudinal change, flexibility of response and training sustainability. There is little emphasis on comprehensive evaluation. Australian general practice itself is evolving and the shift in the gender balance within general practice is only one of the many significant changes impacting on domestic violence management. However, in order to develop more effective support for all victims and in order to challenge those using violence, further research is required into the complexities of the current ways in which different GPs of both sexes and of differing cultures respond to their patients. We need to examine in depth how current methods of teaching about partner abuse contribute to GPs' abilities to respond with greatest effect. Within this context, I have undertaken an examination of GP domestic violence practice and CME in both rural and urban areas. My purpose is to contribute to an enhanced understanding and further development of effective GP training about partner abuse.

CHAPTER THREE: EXPLORING THE OVERLAPPING FIELDS OF FAMILY PRACTICE, PARTNER ABUSE AND CONTINUING MEDICAL EDUCATION

3.1 Introduction

As the previous chapter illustrates, very little is known about many aspects of GPs' relationships with patients experiencing or using abuse. Neither is there much known about how to educate doctors for best practice in domestic violence management. Much further research is needed to illuminate doctors' current practices not only with victimised women but also with their partners and children. Such research may then inform further GP teaching.

Qualitative methods are increasingly being used and appreciated in general practice research for the light they can shed on patients' and doctors' discourse and actions. The illumination of meanings and interpretations of GP and patients' discourse and actions contributes to growing insights into patient/doctor communication. Indeed, observers have suggested that there are many similarities between the day-to-day practice of GPs and qualitative research, suggesting a methodological if not epistemological affinity between the two. GPs use interpretive techniques in their consultations to gradually elicit and construct a multi-dimensional picture of the patient's history, perspective, feelings, values and experiences, similar to the purpose and techniques of the qualitative interviewer (Whittaker 1996). Consultations between patients and their doctors are constructed through language. Doctors mediate their patients' experiences through interpretation and re-interpretation of their stories, which then informs their decisions about the patient and their consequent management. In medical social science research, doctors' narrative constructions of their patients are increasingly being analysed to explore the many layers of patient/doctor interactions and the modes of control and ideologies underlying them (Borges and Waitzkin 1995; Boyd 1996). GPs' narratives of patients and interviews with GPs form the core of this thesis.

GPs are the central focus of this study, but as Warshaw (1997) and others have highlighted, any effective response to partner abuse will be multi-disciplinary and involve the GPs collaboration with specialist workers in the wider community. Any appraisal of GP education on this issue would therefore need to draw on the perspectives of these other stakeholders (Haynes, Davis et al. 1984; Warshaw 1997).

In this chapter I outline my involvement with two pioneering divisional CME domestic violence projects, which have attempted to extend the conceptual boundaries of the curriculum and which form the context for this study. I describe the development and implementation of the two projects, the research design and feminist research philosophy which informed my practice. When outlining the ethnographic methods with which I collected the majority of the data, I include some of the research dilemmas and challenges I faced in studying a sensitive and ethically demanding topic. I then outline the analytic processes and why I found Bourdieu's theory of 'habitus' useful to help unravel emergent patterns within some of the GP patient narratives.

3.2 The GP domestic violence training projects

GP continuing education about violence in the family is in its infancy in Australia. It was pioneered in 1993 by the RACGP's Women and Violence Project. Later, the Australian federal government established the Commonwealth GP Divisional Grants Program in order to stimulate pilot projects, including Continuing Medical Education (CME) in the newly formed GP divisions. Several Victorian GP divisions expressed interest in CME projects on violence in the family. As both a researcher in the area and a policy and programs adviser in family violence, I refereed several divisional domestic violence project submissions. I was therefore aware that a few Victorian GP divisions were planning to train the GPs in their area, and having left the public service, I negotiated with two divisions to conduct research into their funded CME projects. In addition to conducting my own research, the divisions then offered me employment to conduct their evaluation surveys.

The two GP divisions with whom I worked are located in very different areas of Victoria. The inner city division, which consists of both semi-industrial and inner city retail areas, includes many diverse cultural communities, including Arabic-speaking Middle Eastern, Maltese and Turkish families. By and large, it is a socio-economically disadvantaged area. As a cultural contrast, the rural division has a predominantly Anglo-Celtic Australian population, with farming and tourist industries and contains small pockets of serious unemployment. It comprises both large and smaller towns, and a substantial provincial centre. These two divisions represented a wide range of general practices, families, communities and cultures.

Both divisional projects aimed to provide:

- upskilling in the identification and management of domestic violence, victims and perpetrators and
- information and referral resources for GPs and patients.

While the divisions' basic purposes were the same, the two projects were very different in their scope, funding, duration and teaching methods. The urban project offered the RACGP's Women and Violence (WAV) two-hour module on identifying and managing women experiencing violence. They added a further two-hour session on identification and management of men using violence. These were offered twice, once in May and again in July 1997. The victim sessions were delivered by two GPs, who had undertaken the RACGP WAV Train-the-Trainer sessions. The second sessions (about men who abuse) were conducted by a male psychologist from a regional Community Health Centre (CHC) in a satellite town on the border of the urban division. Together with his female nurse colleague, the psychologist ran a regional men's behaviour change group, victim support groups and also children's groups. This was a service to which urban GPs could refer their patients, although it was a considerable distance from the majority of the inner-urban population. One of the training sessions on men who abuse included testimony from a former

abuser who now assists in running groups for other men. Sessions were conducted at the division's hospital based headquarters in the evening and light refreshments were provided. The project also provided funds for a new men's behaviour change group in a more accessible urban CHC, facilitated by the female nurse practitioner together with another male colleague.

The rural division offered the same two hour sessions on identifying and managing both victimised women and men who abused, but offered additional sessions on rape, child abuse, (including child witnesses to partner abuse), crisis counselling, vicarious trauma for the doctor and other associated issues, over ten months throughout 1997/8. The RACGP WAV trainer conducted the women's session and the female worker from the same satellite CHC, together with the same reformed male abuser taught the men's session. A range of invited professionals taught the other sessions, except for a consumer session, in which local women who had been victimised spoke about their abuse and about their experiences with GPs. The rural division also offered networking sessions to bring GPs together with relevant local referral services. These were held at lunchtimes in the six sectors of the division and food was always provided. All upskilling sessions were held in the evenings at restaurants so that rural GPs could leave after work, reach the sometimes distant locations, eat and socialise with other colleagues. (Both projects, together with their achievements are described further in Chapter Six).

These two projects were innovative as both dealt with male partners and one included all family members and the possibility of vicarious trauma for the doctor. I was unaware of any other CME which had used similar approaches. In addition, whilst divisions were established to build better links with primary care community networks, none so far had conceived these as related to abuse and sought to work together with domestic violence related services. The separate locations and innovative curricula offered fertile grounds for research into curriculum development. Having negotiated to conduct the research in these two divisions, I then further clarified the aims and objectives of the study.

3.3 Study questions and purposes.

The overall aim for the study was to investigate the basis for a comprehensive curriculum framework for GP CME domestic violence training, incorporating all members in families in which partner abuse occurs. I decided to explore current general practice with all members of the family and the contribution of current training to improved practice. How do GPs interact with male partners and the children or young people in the family? How were GPs currently managing? In what ways could GPs work more effectively with women, their partners and children? How do GPs relate to relevant referral agencies? What assumptions underlie what they currently do and what assumptions are those on which training is predicated?

Some questions framed for this study include those raised by my previous research:

- *Does the current CME on domestic violence for GPs meet their wants/needs, the needs of women experiencing violence and wider stakeholder/community expectations? If not, how can it be improved?*
- *How can GPs be trained to be more helpful to women from non-English speaking backgrounds experiencing violence?*

Victimised NESB women are more at risk from homicide, less aware of their rights or community resources available to help them. GPs could provide early intervention. Women from non-English backgrounds in my previous study experienced less satisfaction with GPs than English-speaking women (Taft 1995; Head and Taft 1995). Very little is known about cross-cultural communication in general practice, let alone that with NESB women who have been victimised or their families. How could GPs be better prepared to assist them?

- *Does the GP's gender have any role in effectiveness and if it does, how can that understanding inform improved training and better practice?*

Both from my former study and those of others, the gender of the GP appears to affect the manner in which they practice - would this be a factor in GP management of partner abuse and if so, how would this be manifested? How might training take difference into account?

- *What should be the agreed principles and strategies relating to effective GP training with men using violence?*

From my reading and contact with specialists who worked with men, I was aware that there was little background information to guide GP work with men who abuse, so I included an exploration of men who abuse, their health problems and their relationship with doctors. What implications would this have for doctors' management?

I then wanted to understand the strengths and limitations of the teaching offered in the projects to explore the need for further curriculum development.

- *What constitutes an integrated Continuing Medical Education model of domestic violence training, which considered the needs of women, children, men and GPs?*

I decided to conduct a formative case study evaluation of the two projects.

3.4 Study design

The goal of CME is to improve physicians' knowledge and performance and thus to improve patient outcomes (Haynes, Davis et al. 1984). Appraising the development and implementation of an educational intervention requires consideration of four aspects of the intervention: Context, Input, Process and Product (CIPP). Not only should the priorities and concerns of the education provider be considered, but also the nature and political climate of the learning activity (Al-Shehri,

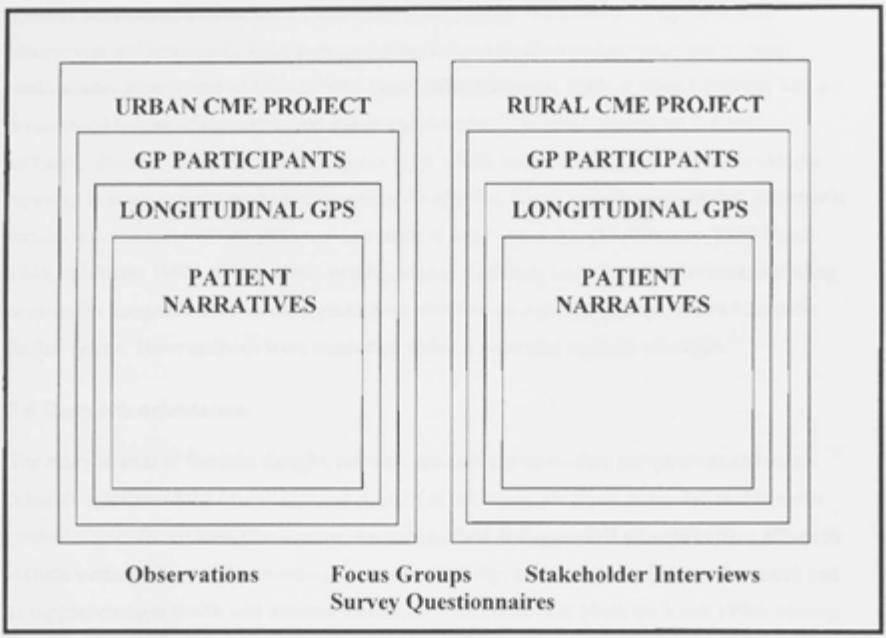
Stanley et al. 1994). The context for this study is the two CME training projects. Exploring the process of their development would clarify the input provided by staff, educators and the GPs themselves. This study can be conceived as a formative evaluation in which the goal is a more comprehensive curriculum, which meets the needs of all the stakeholders, but first and foremost, those of GPs. Formative evaluation seeks to 'improve human intervention within a specific set of activities at a specific time for a specific group of people' (Patton 1990 p156).

The overall design involves case studies of the two divisions' training projects and processes. A case study has been defined both as process 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context' and as an entity or unit around which there are defined boundaries (Yin 1994; Merriam 1998). The advantages of case studies in evaluation are that they can explore complex causal links; can connect program implementation with program effects; can describe or illustrate and explore where there was no clear, single set of outcomes (Yin 1994). Merriam explains that 'by concentrating on a single phenomenon or entity (the case), the researcher aims to uncover the interaction of significant factors characteristic of the phenomenon. Qualitative case studies are *particularistic* (focussing on particular phenomena), *descriptive*, (providing a richly textured, thick description) and *heuristic*, (illuminating the reader's understanding, uncovering previously unknown relationships or stimulating a rethinking of the phenomenon) (Merriam 1998 pp29-30).

Within the overall context of the divisional case studies, focus groups with stakeholders, observations of the training, survey questionnaires and further interviews with policymakers and educators and specialist workers contribute to understanding the divisional case environment. Interviews with urban and rural GP training participants are embedded within the two case design and embedded within those two groups are consecutive interviews with particular GPs for up to a year. From within each longitudinal GP case, individual patient narratives have been extracted.

The design is represented in diagrammatic form below in Figure 4.

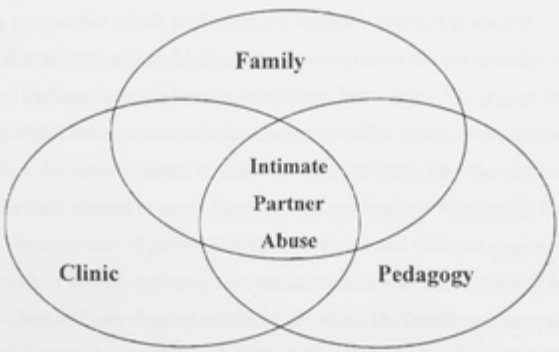
Figure 4. Study design



3.5 From design to method

This research involves three distinct domains and examines their intersections – patients who are family members living with violence, clinical general practice and medical pedagogy. The conceptual domains of the study are illustrated in figure 5 below.

Figure 5. The three domains of the study



I wanted to explore each of the three domains of interest within each project from the GPs' perspective. Because of the study's GP focus and complexity, I drew on several sympathetic epistemologies and methodologies within the interpretive arm of social science. The design consists therefore of a portfolio of multi-method approaches. Such methods, eg participant observation and interviews, have been used effectively in medical anthropology and to study medical education (Good and Good 1993; Good 1994; Kleinman 1995). Cultural diversity was a pronounced feature of the urban community and the urban GP participants were themselves culturally diverse. Medical anthropology is a field, which uses ethnographic methods to explore meaning in cross-cultural medical interactions. In addition, Kuzel and others argue that naturalistic inquiry is consistent with the philosophical basis of family medicine (McWhinney 1975; Kuzel 1986; Whittaker 1996). Within these methodological traditions, I conducted interviews, including consecutive longitudinal interviews, participant observation and focus groups, which I describe further below. These methods were conducted within a particular research paradigm.

3.6 Research orientation

The many strands of feminist thought, research principles, post-modern perspectives and praxis orientation informed the overall aim and conduct of this study. De Vault points out that feminist methodologies do not prescribe any one research method, but are united through various efforts to include women's lives and concerns in accounts of society, to minimise the harms of research and to support changes which will improve women's status (Nicholson 1990; De Vault 1996). Having learnt from women who had experienced violence in my previous study the problem they had with general practice and what they wanted from doctors, this research considered whether GP training was achieving their aspirations, and if it didn't, how these could be reached. Women's perspectives about their needs were an important reference point for the study. The ethics of feminist research demand self-awareness about the authorship and research standpoint, in my own case, an acknowledgment that this study has been undertaken by a middle class, middle aged heterosexual married woman from a European refugee family who has never personally experienced partner abuse or racism.

Feminism is a perspective which problematises women's position in society. Feminist scholarship is often trans-disciplinary and multi-disciplinary, recognising the connectedness of human experience and challenging and blurring disciplinary boundaries. We engage in ongoing critique of scholarship which renders women's experience invisible or distorted (such as use of the CTS as a tool to measure domestic violence or research which seeks to limit the explanation for battered women to individual women or men). Feminist and pro-feminist scholarship has long been engaged with the dynamics of gender relations, medicine and violence against women. This includes the work of female and male scholars concerned with understanding how to develop and sustain non-violent and non-abusive relationships within the family and beyond to the systems and societies which surround them (Flitcraft 1995; Edleson 1997; Gondolf 1997; Heise, Ellsberg et al.

1999). Feminist praxis-oriented research challenges the status quo and is oriented to transforming gender relations and society for the better. Such is the goal of this study (Lather 1991; De Vault 1996).

3.7 The research process

The design for this project was approved by the Ethics in Human Experimentation Committee of the Australian National University in April 1997.

3.7.1 Establishing an advisory panel

This study was focussed on general practice and domestic violence. In order to enable the study processes and outcomes to be informed by, useful to and respectful of GP perspectives, and relevant to the needs of victims of violence, I established an advisory panel.

The group consisted of: a female GP trainer from the Women and Violence Project, RACGP; trainers from the Domestic Violence and Incest Resource Centre; the then Executive Director of The Centre for Culture, Ethnicity and Health; a female GP DV researcher; and later a male GP who also runs a men's behaviour change group. It included the GP project managers from the two divisions.

Members of the panel advised me individually on the appropriateness of the questions both for GP pre- and post-training interviews and questionnaires. I consulted them individually at different points in the study and then convened them as a group once towards the end of the study to check interpretations. I also consulted individual members in the latter part of the study to check the accuracy and relevance of my representation.

3.7.2 Understanding the GP divisional project context

I was contracted by the two divisions to develop and analyse their formal pre- and post-training evaluation survey. As a consultant, I enjoyed good relationships with the staff in both divisions, as I was perceived as an expert in the area. In return, I offered to share my expertise with project staff. My position offered privileged access to the doctors, as the divisions offered both written and verbal support to my project.

Early in the study and prior to the commencement of the training projects, I interviewed the following people to elicit their organisation's perspectives on GP education about domestic violence:

- A policymaker from the Commonwealth GP Branch
- A representative from the GP Education Support and Evaluation Resource Unit
- Two representatives from the Victorian Community Council Against Violence, a state wide policy body

- A representative from the Commonwealth Department of Health, Housing and Human Services' National Women's Health Program .

Following written consent (Appendix A), each interview was taped and transcribed by a professional transcriber (who transcribed all the tapes in the project). The transcripts were sent to the interviewee, if requested on the consent form, for checking. They were then entered into QSR NUD.IST Version 4 (N4), a data management and analysis software package, and checked for accuracy against the tape (Qualitative Solutions and Research 1997). This process was repeated with all interview subjects.

3.7.3 Program implementation

To gain insights into the processes, goals and aspirations of the divisions, I interviewed divisional staff. Prior to the training, I interviewed the two divisional project development officers (PDO), who were responsible for developing domestic violence and other project submissions for funding. As funded projects commenced, I interviewed the two GP project managers and their two project officers. All staff were female. GP managers have nominal responsibility for the overall detail of project curricula and their project officers for the implementation. I interviewed these staff both before and after the projects to compare their perceptions about the goals, obstacles, achievements, and limitations of the two projects. The semi-structured interviews followed written consent and were also taped and transcribed.

3.7.4 Recruitment.

I spent several months liaising with both division's project officers and GP project managers to familiarise myself with the divisional context and their needs for the pre-training survey. If asked, I provided staff with literature and relevant contacts. At the same time, I negotiated a process for access to the GPs prior to the training. Both divisions sent a letter from me to participant GPs (Appendix B) explaining who I was and the nature of the study, together with a covering letter of support from the division. The letter explained that I would be contacting the GPs by phone to negotiate an interview of approximately half an hour before and after the training. It also requested GPs to contact the division if they were unhappy with my having their contact number. As far as I am aware, no one did. In the rural area, I was also invited to a preparatory meeting, which sought input into the project (from four women GPs). This allowed me to meet and attempt to recruit these GPs.

3.7.4.1 The GP sample

I was able to draw a purposeful (information-rich) sample from those GPs who sought training to better manage domestic violence. These GPs, I assumed, would be those more interested in the needs of patients living with violence and more likely to be identifying and managing at least some victims and/or perpetrators. However, as I was interested in the practice of female and male GPs, the sample could better be described as a stratified purposeful sample, as I was careful to

include proportional numbers of female and male GPs to those participating in the training (Patton 1990). Australian GP divisions consist of GPs who live and/or work in the area from which divisions draw a membership. Divisions do offer training to all GPs, but members are more likely to receive promotional material and more focussed attention from divisional staff.

3.7.4.2a The urban sample

The urban division attracted only 17 training participants. I approached sixteen, excluding one man who was from NSW. All agreed, but one interview with a female GP was cancelled due to family circumstances. Another Middle Eastern solo female GP intended to come to training, but both times was unable to attend at the last minute. After I had conducted her pre-training interview, I found that she was a 'critical case' as she saw many Arabic-speaking couples and was experiencing great difficulties herself. I decided to conduct another interview with her anyway to discuss the issues for her community further.

This resulted in 15 urban participants. Of the fifteen, there were seven women and eight men, directly proportional to the GPs in the division. Eight GPs were from NESB backgrounds themselves. Of the NESB doctors, five were from the Indian sub-continent, one was Southern European, one Middle Eastern and one was from Latin America.

3.7.4.2b The rural sample

The rural division's initial recruitment yielded about 19 starters. The majority was female. I wanted the proportion of the rural sample to reflect the gender balance among participants, while not exceeding the urban sample in number. I was satisfied to over-sample rural GPs in proportion to the urban sample, as the domestic violence problems in rural areas are different from those of the city (where more resources are available). I approached twelve GPs (four male and eight female) and all consented to interview. Of these, some were only approached after the launch of the project through the project development officer and a few were interviewed after the first event due to their unavailability. One extra GP was recruited as a replacement case study, but after one interview, he withdrew after taking on an antenatal clinic.

Table 2. Characteristics of the GP study sample

Age	Rural	Urban	Total
Women under 40	5	4	9
Men under 40	1		1
Women over 40	3	3	6
Men over 40	4	8	12
Total	**13**	**15**	**28**

Most participants were over 40, and more (15) were female than male. Eight were from non-English speaking backgrounds. Similar to Australian GPs in general, the female GP participants

were, on average, younger than the male GPs. The majority of female GPs were practising part-time, while male GPs were more likely than female to be full-time. All except one rural female GP either had vocational registration or were in the process of acquiring it.

Recruitment to CME about this issue is very difficult in the currently demanding GP environment. The fact that overall more participants are female conforms to patterns in the WAV project. However, it was noticeable in the urban project, that the trend was reversed with slightly more participants being male, in proportion to the GPs in the division. This sample consists of voluntary participants. That proportionally many more female than male GPs are involved in domestic violence CME to improve their practice may reflect the fact that female GPs attract more psychosocial problems and therefore have more patients to manage (Britt, Bhasale et al. 1996).

Following their recruitment, I began to interview GPs prior to their commencement of training to find out why they were training and what they wanted of it.

3.7.5 GP pre- and post-training interviews

Pitts et al highlights the difference between 'wants' - which are doctors' perceived needs or educational desires and their educational 'needs' which are defined as 'external perception of their required learning' (Pitts, Percy et al. 1995). I interviewed GPs before the training commenced to elicit their 'wants' and compare these with their 'needs' as defined by the literature, by victimised women and by other stakeholders. Interviews were the primary method I used to explore doctors' experiences and reflections on their current practice. As McCracken argues, interviews allow the researcher 'to gain access to the cultural categories and assumptions according to which one culture construes the world. How many and what kinds of people is not in fact the compelling issue. It is the categories and assumptions, not those who hold them, that matter' (McCracken 1988 p17). The interviews may be limited by recall bias and some social desirability bias.

I was always careful to negotiate politely with the doctors' receptionists, who are cautious protectors of their employers' time and stress levels and good sources of information about the practice. As doctors were giving their time freely to me, half an hour was the limit I set for a feasible interview covering all the themes and this timing was indeed adequate. When I arrived at the agreed time, doctors signed the formal written consent forms. I conducted interviews with urban participant GPs just prior, and between eight to ten weeks after training, taping all interviews. In the rural division, the post-training interviews were conducted between six to eight weeks after the project ended. Because the project continued for ten months, for some GPs the post-training interview may have been a considerable time after they attended an upskilling session. Interviews were scheduled for half an hour and were half an hour on average, but varied from fifteen minutes (an elderly locum GP) to fifty minutes. For each of the pre-and post-interviews, I broadly followed the same questions (Appendix C), which were drawn up in consultation with the advisory panel. Themes covered motivation to train, personal learning goals,

current practice, perceptions of gender issues in practice and reasons behind other GPs' non-attendance.

After the training, my questions sought GPs' perceptions of their learning achievements, any conscious practice changes, views of training and teachers and any remaining learning gaps. The questions were not necessarily all introduced in the same order, nor using the same wording, as interviewees ranged from elderly Indian gentlemen to 'hip' young female GPs and answers could often be included in earlier questions. Most interviews were conducted in the GP's surgery, or in rare rural cases, over the phone. All interviews were taped and transcribed. Copies of transcripts were sent to those who requested them. No one contacted me to report any errors or concerns. During some of these interviews, doctors told me stories of cases, which they had found or were currently finding difficult.

All interview data are limited by the GPs ability to recall patient details and events, which happened some months ago in several cases. This was the case with some rural training events. This learning amnesia is itself telling. On the other hand, partner abuse cases can be severe and confronting (critical incidents) and most doctors were keen to discuss the issue with me. The doctors who checked their transcripts did not want to alter anything.

3.7.6 Longitudinal GP case interviews

The long interview, described as 'one of the most powerful in the qualitative armoury' is a strategy designed to explore respondents' perceptions and views of their world in depth and in their own terms (McCracken 1988). In this study, the purpose was to learn more about doctors' insights and practice with patients who experienced intimate partner abuse. How do GPs construct the victims and perpetrators in their patient populations?

> *The person is a cultural construct. A complex and culturally shaped way of experiencing self and other... which combines culture and ideology, interpersonal relationships and development. Cultural 'work' is required to reconstitute the person who is the object of medical attention (Good and Good 1993 p97).*

To recruit longitudinal interviewees, once I had completed pre-training interviews, I approached those GPs whose first interview suggested that they had a variety of patients and perspectives. I wanted a balance between gender, ethnicity and location in this purposeful stratified sample. I also needed GPs who were willing to speak with me for at least an hour up to a further six times after the first pre-training interview. I approached six GPs, three in the country and three in the city, three women and three men. All agreed.

Three doctors, (all referred to henceforth by their pseudonyms) cut short the full six interviews – Dr Jill McPherson[3] because of illness, Dr Peter Greenway's marriage ended and Dr Harold

[3] All the GP and patient names are pseudonyms

Rosario believed he was seeing too few new patients and therefore domestic violence wasn't a significant issue to discuss. Three other GPs spoke to me a further six times. When Dr Rosario cut our interviews short, I approached a rural male GP whom I had recently met at an upskilling session and he agreed, but dropped out after one interview, as he had commenced obstetric practice and was overwhelmed with work. When Dr McPherson became seriously ill, I approached Dr Sally Morris who had attended most of the training events and had practised in both divisions. She agreed and I interviewed her a further five times. I negotiated written consent and interviewed all but Dr Rosalie McLeish at least once in their clinics. I had met and talked with all the longitudinal interview participants at the training events. Consequently, in total I interviewed seven GPs in consecutive long interviews.

Each doctor was interviewed every eight and a half weeks on average (ranging from once a month to once in three months in holiday periods). Each interview lasted at least an hour and yielded many hours of interview with each of the seven participants. The majority of interviews were conducted over the phone as most doctors preferred this. It enabled them to be interviewed at home, for some in the evening after work, when they had time to reflect. Some interviews were at the doctor's practice, a few in my home. In all but one case, the interviews were taped. In that one instance, I took notes and wrote them up immediately afterwards.

The GPs charted the progress of their management of particular patients with me over time and I learnt when and how the training affected their courses of action. I kept a record book in which I made careful note of key points about patients, practice issues and concepts. The doctors and I agreed on a code-name for each patient to preserve their anonymity. In some cases, in order to aid their memories, GPs either brought their patient files with them or had their computer open when we spoke, so they could access files. This strengthened their accuracy and recall and the data's trustworthiness.

The interviews were mostly open-ended to allow both the GP and me the flexibility to pursue whatever direction appeared most germane. Often subjects would emerge from our previous interview or the training events. With some doctors, as well as following particular patients, I occasionally followed a specific theme, eg counselling or working with NESB patients. I gained a deeper understanding of the doctors themselves, the tremendous demands on their time and person, the complexity of their caseloads, their perceptions of patients and the considerations and judgment they brought to the 'contingencies' patients presented. It also allowed me to explore what learning or experience doctors tapped in their work. Quite often, the sources were rich and unexpected. The seven case doctors who provided longitudinal data on their patients differed in almost every significant respect. They differed in age, sex, practice type, time in practice, types of practice and cultural background.

3.7.7 Profiles of the doctors who participated in longitudinal interviews:

Rural doctors:

1. Dr Peter Greenway

Dr Peter Greenway is an Anglo-Australian rural male GP in his mid 50s. For the last ten years he has practised medicine with his GP wife in their family practice in a small country town. They own another practice in a nearby town. Dr Greenway is committed to his town community, involved in community charitable organisations and enthusiastic about his practice. He is very interested, whilst largely self-taught, in counselling and devotes at least one evening a week to providing motivational counselling for patients with psychosocial problems. The practice also employs nurse practitioners, paid for from the practice budget. Dr Greenway teaches on the RACGP training program, where he highlights abuse issues, as he has successfully managed some longstanding hidden incest survivors whose stories had never previously been disclosed and whose consequent health problems had been great burdens until disclosure.

2. Dr Jane Norton

Dr Jane Norton is a single, quietly spoken, Anglo-Australian female GP, in her late twenties, two years into general practice and five years out of medical training. She has her Fellowship. She worked three days a week at a family practice in a satellite town in the rural division and in town for a few sessions on other days. The satellite town has recently expanded and has many young families seeking less expensive housing. It consists of a largely non-NESB population. Dr Norton has worked in an inner city community health centre, where she managed a wide range of psychosocial issues, including drug and alcohol problems. The satellite family practice where she worked employed an even balance of male and female doctors, some of whom were active in the division. The practice was well regarded for its participation in broader community health activities. She has since left this clinic and moved back into urban practice.

3. Dr Sally Morris

Dr Sally Morris is an Anglo-Australian rural female GP in her mid to late 30s. She works 3 days, 12-16 hrs a week at present, as she has a small child. She has been working in a small country town for only two years and has been building up her practice. The practice teaches on the RACGP training program and Dr Morris participates in the teaching. The practice has three full time male partners, an older three-quarter time female partner and a part-time male GP. Dr Morris has worked in an inner urban division and was able to compare her practice in this small comfortable and pretty country town with her experience of a multicultural inner city poorer population. In her urban practice she managed many cases connected with serious family dysfunction. She is actively involved in the rural division. She is strongly interested in counselling, among other GP skills.

4. Dr Rosalie McLeish

Dr Rosalie McLeish is a single, Anglo-Australian GP in her late thirties who left a related profession and went into rural general practice six years ago. She lives and works in a country town with high unemployment. Due to a bureaucratic technicality, she doesn't have her vocational registration, which is financially disadvantageous for her. She practises almost full-time to maintain her salary although she would prefer not to, as she enjoys creative and other pursuits. She is interested in strengthening her counselling skills, as she sees a large number of patients with psychosocial problems. Dr McLeish has some sexual assault training and has worked with sexual assault services. She works six sessions at the rural practice, which has four equivalent full time (EFT) staff. Another female GP undertakes a few sessions, whereas the male GPs are full time.

Urban doctors

1. Dr Harold Rosario

Dr Harold Rosario is a full time solo male doctor in his mid fifties from Southern Europe, who conducts his family practice from his extended house in an outer suburb of the inner city. He employs his daughters as receptionists and his wife as practice manager. He enjoys practising as a family doctor in the 'old style', conducting home visits and valuing his longstanding relationships with his patients. In his home country, Dr Rosario practised marriage guidance as well as medical practice. Dr Rosario takes trouble to remain up to date and informed on developments in professional training. His work is informed by his strong Christian beliefs and he is active in his church community. He is very involved in his ethnic community also, particularly in the Arts. His patients are predominantly from his community.

2. Dr Jill McPherson

Dr Jill McPherson is a 33 year old Anglo-Australian female doctor, with two small children, who works part-time (five sessions) in a maternal and child health clinical outpost of a large inner urban Community Health Centre (CHC). The clinic is situated amongst houses in a very deprived inner urban area on the outskirts of an industrial estate. There are two female doctors at this clinic, where there are 10 equivalent full-time (EFT) doctors at the main CHC. The area has a high proportion of NESB communities, including Turkish and Arabic speaking Muslim people. Dr McPherson has travelled to Turkey. The clinic employs a social worker and Dr McPherson is a regular user of the social worker, the CHC's bilingual workers and the Community Health Interpreting Service. She has worked at the clinic for eight years.

3. Dr Errol Threadgold

Dr Errol Threadgold is an Anglo-Australian male urban GP, in his forties, with teenage children. He works in a working class, multi-racial, industrial area of Melbourne. The private clinic in which he is a partner is multi-disciplinary, with both a pharmacy and pathology attached. It contains consulting rooms for both GPs and specialists, including rooms for paediatric specialists.

It employs physiotherapists, Turkish and Arabic speaking psychologists and receptionists and specialises in workers' compensation issues. Dr Threadgold has attended cross-cultural educational sessions and actively attempts to read and understand cross-cultural issues for his NESB patient community. He has been very involved in the division and is active, informed and interested in wider GP policy issues.

3.7.8 Constructing patient narratives- three degrees of separation

Each time I spoke to the doctors, I would inquire about whether they had seen the patients spoken of in the previous interview or whether they had any new patients they could discuss with me. Consequently, scattered throughout long interviews were the fragmented narratives of particular people and their families. Through coding each reference to a patient separately, I was able to extract narratives of individual patients, those who attended in couples at times and those who came with children. Some attended once and never appeared again. Others attended over the entire period, such as Dr Jane Norton's patient Mrs Davis, who came with and without her children throughout the interview year.

Following the coding and retrieval of the narratives (Appendix 1), I summarised them, distilling the gist of the perceived interaction. The use of verbatim quotes aims to bring the doctor's voice as much to the forefront as possible. They represent my understanding of GPs' perceptions and interpretations of patients. I then sent each doctor the three summaries of their patients appended to this thesis, together with the description I had written of them. I asked for feedback about factual errors, updates on the patients, further de-identification of patients or any other corrections or reflections they wished to make. They also had the option not to respond if they were happy with them. Dr Errol Threadgold sent me confirmation and updates. Dr Jane Norton rang to say she was happy with their accuracy and had moved to another practice. Dr Peter Greenway's clinic rang to say they were fine. I did not hear from Jill McPherson, Dr Rosalie McLeish nor Dr Sally Morris. One GP deserves particular comment.

Dr Harold Rosario wrote with updates. Although he did not clearly express concern about these stories, he had not recalled calling Mrs Starelli 'stupid' and commented on Mr and Mrs Mizzi that they appear happier and that (in bold in original) 'the patience and the counselling produce results if one is prepared to wait!' Dr Rosario is a proud man. I conducted his post-training interview too soon after a case interview. This allowed only a few weeks interval between the early interviews. This frequency elicited the following comment from him. '*I had started to experience such a revulsion to the subject that even thinking about it made me feel sick. I sympathise with those families that go through these abusive experiences and try to help them professionally but speaking about the subject at length became repulsive.*' This 'repulsion' was neither obvious nor expressed at the time. Indeed Dr Rosario was a co-operative and willing interviewee, but the possible expectation of progress or new cases within a short time and his reflection (in italics) on

the difficulty of dealing with such cases made progress in the interviews difficult. He decided not to continue.

The credibility of the narrative data appended for the reader is strengthened by the fact that doctors confirmed to me that the narratives conveyed what they said about these patients and they did not want to change them.

3.7.9 Interviewing educators

The conceptual input to the CME training projects was defined to a large degree by the trainers themselves. For comparison, I first interviewed two female trainers from a Victorian state wide domestic violence agency, who had delivered some brief GP domestic violence training. I next interviewed the projects' educators. Interviewing the disparate trainers one-to-one allowed me to explore their concepts of partner abuse, their knowledge of general practice, their educational aims and objectives, the rationale for their methods and their assessments of the training. I interviewed both GP trainers for the victim session of the urban project before and after the training sessions. One was the urban GP project manager. I also interviewed the male and female trainers for the session on men who abuse. I interviewed them together and then both separately after the training. As these two trainers conducted the training in both divisions, I used the interviews to explore both projects. Interviewing these trainers confirmed how little was known about GPs and men and resulted in my adding focus groups about men to the original design. As there had been some dispute about the orientation of the projects' male trainers, (too much focus on men's feelings) I also observed three GP training sessions given by the male GP on the urban reference group, whose perspective on teaching GPs about men who abused emphasised patriarchy, but was in danger of alienating GPs.

For the rural project, I interviewed educators on child abuse and children who witness partner abuse, violence against women, community policing and child protection, crisis counselling and vicarious trauma. This resulted in interviews with thirteen trainers, some several times. All interviews followed the same pattern for all interviews in relation to consent, taping and transcribing accounts.

3.7.10 Participant observation or the research epicurean

Reflecting on the methods he used in his famous study of medical students, Becker claims that participant observation 'gives us more information about the event under study than any other sociological method.' It is the 'yardstick' against which all other information can be assessed (Becker and Geer 1957 p28). Observations provided me with an opportunity to experience the training sessions at first hand and closely observe the interactions of participants with the educator and with each other. Certainly, observation of training informed my interviews with doctors, with educators themselves and did, as Becker claims, allow me the yardstick with which to compare doctors' responses to the training and networking sessions with my own observations.

The first round of urban training sessions was conducted at the division's hospital headquarters, and I observed this but was unable to attend the second. The 11 urban GPs were asked and gave permission for me to attend once I was introduced, as all GPs had received the letter (Appendix B) explaining my participation from both the division and me. I did not comment or take part in role-plays, merely answered questions as a visiting 'expert' when asked - eg the rate of abuse in pregnancy.

I observed all but two of the rural upskilling sessions. In all rural upskilling sessions, the locations were restaurants or very congenial locations with good catering and wine, as they were encouraging doctors to attend after work, which often required up to an extra hour's drive. Networking amongst doctors was also a goal of the rural project and this provided a good opportunity for doctors to socialise with colleagues they may not have met. Rural GPs who were regular upskilling participants became familiar with me, which allowed more informal discussion and observation. Attending these sessions allowed me to observe when training concepts conflicted with each other, as when the crisis counselling family systems trainer used a stereotype of the 'nagging wife' to talk about relationship dynamics in contrast to the RACGP WAV trainer who was directly challenging such stereotypes.

In the networking sessions which all followed the same model, a local GP would present a current case, which s/he considered challenging or difficult. Local service providers then introduced themselves and their agencies and explained what their service could provide in that particular case. I attended three of the rural networking sessions, presented by three of my interviewees. This enabled me to discuss the cases further with them and their responses to service providers' feedback.

Generally, I took no overt role in the training, sitting discreetly towards the back. However, I was asked to make up a pair in a role-play during the WAV training and during some upskilling dinner breaks, I talked informally with doctors. In all cases, I took field-notes and typed them directly into the computer as soon as possible.

3.7.11 Focus groups.

In interviewing doctors, I sought to understand their individual needs, practice and responses to training. Sampling allowed me to adjust for GP gender. Focus groups, on the other hand, allow the diversity of views or patterns of agreement between participants to emerge in guided discussion and have also been proven useful in primary care research in general and those concerned with GP partner abuse (Wood 1992; Brown, Lent et al. 1993; Morgan 1996). There were particular issues of concern in this study (the health experiences of men who abuse, their help-seeking and experiences with GPs and those of the needs within culturally diverse communities) where I sought the views of groups of interviewees.

3.7.11.1 Talking about men who abuse their partners

Early in the life of this study, I learnt how little was known about the health of men using violence. I also discovered that approaches to working with them (in behaviour change groups) were keenly contested. In order to inform my understanding about how men themselves perceived their health issues and their doctors and how workers with men perceived these and what GPs needed to know, I approached two groups, which together offered a strengthened view of those men who had sought help. Therefore it is not indicative of men who have not accessed help.

I sought access through the community health centre, which provided training and men's behaviour change groups. I negotiated with workers to approach men in the leaders' group to speak with me. These were men who had used violence, but whom the workers now judged had been through a sufficient number of groups, that:

(a) their abuse had either significantly diminished or ceased and

(b) their attitudes were sufficiently transformed to be trusted to provide peer examples to men just entering the program.

Four men agreed to participate and I conducted a focus group interview with them. I thought that men would be more comfortable in a group process to which they were now acclimatised - turn taking, consensus and respectful disagreement were skills to which the men were now accustomed. I was less confident about my own demeanour.

One of the men was Barry, the man who gave vivid consumer testimony in the GP training sessions. Barry, Mick and Owen could be described as cyclically emotionally volatile abusers. Barry and Mick were blue-collar workers but Owen was a tertiary educated lecturer. These men had been generally threatening or violent to workmates as well as to partners. The fourth, Rod was newer to the men's program. He was a meticulous craftsman who still spoke euphemistically of 'troubles for my wife and I'. I worried about how I might respond knowing that these men had seriously abused their wives. The perspective on which I focussed to guide my behaviour was the respect for the fact that these men had sought and achieved change for themselves and their families. Without more changes such as theirs, the problem of partner abuse would not be solved. I was so concerned the men not judge me critical, that in one instance Mick pointed out I was being euphemistic and corrected me -'you mean violence!' The group discussion developed easily and the result was fruitful.

The second group was the Victorian Network for the Prevention of Male Family Violence (now referred to as No To Violence). This group was the peak body for those men and women either providing male behaviour change groups or individual therapy for men using violence. This group of men and women usually met together with staff and volunteers from the Men's Referral Service, the Victorian telephone counselling and referral service for men (sometimes their partners or friends and family) seeking assistance with male violence. I had previously been responsible for

developing standards in this field and providing administrative oversight of these groups in my former public service role, so I knew the key players well. They allocated an hour in their next meeting to participate in a focus group about men and their help-seeking, counselling men and training issues. Of the ten participants, one was female. Both focus groups were recorded and transcribed.

3.7.11.2 Talking about cultural diversity and collaboration

Turkish, Vietnamese and Arabic-speaking Muslim families comprise the majority of culturally diverse communities in the urban division. As bilingual domestic violence workers offered vital assistance to families and potentially to GPs also, I sought their perspectives on the needs of family members and any contact workers had with GPs or victims' experiences of GPs. In the end, so few GPs saw Vietnamese patients, that I did not pursue more information about Vietnamese families, but focussed on the SE European community of Dr Harold Rosario. I was interested in the workers' perspectives on any GP experiences to date. I contacted the Immigrant Women's Domestic Violence Service (IWDVS), Women in Industry and Community Health (WICH - a NESB women's health service) and the large community health centre in the urban division, which provided bilingual workers also. I asked to speak with the Vietnamese, Turkish and Arabic-speaking workers. This resulted in two focus groups, one in the WICH headquarters and another in the health centre as different groups of workers attended each. The first group (n= 6) was all female, but the second group (n=5) included a young male Lebanese social worker. These sessions were taped and transcribed.

3.7.11.3 The rural reference group evaluation focus group

The interview with this group was serendipitous. The members of the rural project's reference group decided to incorporate their final group discussion in feedback into the formal evaluation they were required to make to federal government. I therefore conducted an evaluative focus group with the five women members: the project worker, the GP manager, a social worker from the CASA, a rural domestic violence worker and the victim/survivor who was one of the women who offered consumer testimony in the victim session. The focus group was taped and transcribed.

3.7.12 Child survivor interviews.

Whilst the needs of children were always present in my mind, the recording of two in-depth interviews specifically on these issues was also largely serendipitous. One developed from an interview with a rural domestic violence worker whom I was interviewing as part of the stakeholder interviews. In our discussions, it emerged that she had grown up locally in a family with violence and I asked her to reflect on her experiences and that of her parents, brothers and sisters. Similarly a colleague at the centre where I was studying revealed that she had grown up in a family abused by her alcoholic father and grandfather in the rural division. She was willing to be interviewed about her family's experiences and reflect on her own struggles and successes and the

trials and help-seeking of her siblings and other family members. Both interviews of a few hours long were taped and transcribed.

3.7.13 Knowledge, Attitude and Practice questionnaires

My contracted work for divisions consisted of the design, analysis and reporting on the pre-and post-training surveys (Appendices 4 & 5). These were the customary evaluation and accountability tools for funded CME projects. A report of each survey's findings was incorporated in the division's final report, which sought more information on processes and budgets. Surveys such as these suffer from many limitations, including non-random sample sizes and self-reporting. The response rates were uneven. 15/19 rural GPs completed the first questionnaire, and 17 the second. 11 completed both (80% response rate). 15/16 completed the first urban questionnaire and 11 the second, including one GP who had not completed the first (73% response rate).

The survey questionnaires included both closed- and open-ended questions, as staff sought a range of information, from reported identification rates to information about GPs' motivation and felt learning needs. The rural project staff added questions eliciting GPs' priorities for topics and skills to acquire, which were taken into account in their planning processes. The questionnaires were designed in collaboration with divisional project staff and reference groups and in consultation with the GP Education and Support Evaluation Research Unit (EDSERU). As much as possible, I retained the same questions for both divisions.

The time-lines for projects placed restraints on the piloting of questions, which was undertaken by GPs on the divisional and my own reference panel. The divisions took responsibility for the survey distribution and collection. Both sets of pre-training questionnaires were mailed to committed participants prior to the training sessions. GPs then filled them out in their own time. Both urban and rural pre-training questionnaires were returned by mail, but non-respondents were followed up in person in the rural areas.

Post-training questionnaires were distributed differently. While the urban project mailed out the final questionnaires, the rural project distributed them at the final upskilling session, so that they were completed only by GPs attending the session. The rural reference group was also interested in a preliminary data analysis for discussion at their final meeting and their reflections were included in the final report. I analysed the data and reported on them in both instances. The final rural report incorporated an analysis of individual sessional evaluations. In both cases, my final reports (Appendices 4 & 5), while being welcomed and praised, were appended to the report in the required Commonwealth format and a 'revision' emphasised the strengths and minimised the less successful results of the project. The rural project won a rural CME award.

I also designed other evaluation forms for the rural project. One was a monitoring form for newly identified victims over the duration of the project. Only one GP, Dr Rosalie McLeish, completed it. Another form was designed to survey GPs' views of the usefulness of the resources map (a double-sided laminated sheet with dot point actions for identification and a list of useful up-to-

date referral contact details). The resource map was sent to all 142 divisional doctors and the survey completed by 23 GPs. Twelve said they had not received the map, eleven had read it and two used it. All of these data are very limited by the sample size and method, but I refer to them for comparison as the trends in these data are consistent with the data from the other sources.

3.8 Issues in research

3.20.1 Reciprocity in interview research

Interviewing study participants about abuse in families is an intense and demanding activity for both the researcher and her subjects. Maintaining both professional distance and empathic engagement is always a delicate balance, but at times positive engagement was compelling. Some doctors, like Dr Rosalie McLeish and Dr Jane Norton used the interviews as an opportunity to debrief, as there were very few opportunities to do so. At times, the interviews came soon after a critical incident, such as Dr Norton's patient, Mr Connor's self-mutilation. At one point, a female doctor's state of exhaustion and distress was so worrying that I rang early next morning to check that she was alright. Female GPs were more likely than male GPs to ask me for reassurance about their practice or information they had missed. I felt it would be unethical to refuse such requests (Oakley 1984). I sent articles on topics raised by the interviews, eg guidelines about seeing both partners, and gave confirmation of good practice, when it conformed to beliefs I had formed after listening to women, reading the literature and talking to workers. Not to do so would have been contradictory to my purpose in the research (to strengthen GP practice).

Other doctors used the interviews to reflect. Doctors' reflections were also in themselves, revealing. For example, Dr Errol Threadgold reviewed his own and his clinic partner's case notes, which he had brought to the interviews (he clearly rarely had time to do so). He reflected on one particular case -'It's interesting, when you start to talk about it like this, you begin to wonder whether you're missing a whole lot of things.' In other instances, my asking a question, often about children, clearly raised the awareness of this issue as a problem to be considered. Similarly, by asking about them, I informed GPs of resources they were unaware of, and thus, I became in a small way, another educational resource.

3.20.2 Ethical dilemmas

At the end of my case interviews, I had narratives in which GPs disclosed that they had not reported cases of physical and psychological child abuse, despite Victoria's mandatory reporting laws. I also knew from GPs' narratives that many of the women experiencing violence and their children were still vulnerable to this abuse, but felt unable at that point to make changes and that GPs felt unable to help them. This positioned me between the rock of secrecy and collusion and the hard place of breaching confidentiality. Without consent from either the GPs or the sufferers, I had neither the right nor sufficient information to report any of the cases troubling me.

3.9 The trustworthiness of data

I have described the many methods I used to collect the data in this study. I have alluded to the limitations and strengths of each as they have been described. The major limitation of interview data is the reliance on recall by professional people with very demanding workloads. To offset this with patient narrative data, I sent the narratives for doctors to check. Similarly, every doctor was offered the option of checking interview transcripts if they wished. Many did, but none wished to alter them.

In order to ensure that the descriptions of the two projects were accurate, I sent copies of what I had written in Chapter Six to the two GP project managers to check for accuracy. Both GPs confirmed their accuracy. Some interviews may have been affected by social desirability with doctors keen to impress that they are 'doing the right thing', but as many were unaware of good practice, this is unlikely to be the case overall. I have appended a large amount of material so that readers can judge their quality for themselves.

The strength of the study lies in the appropriateness of the design to the study purpose. The 'triangulation' of data sources strengthens the trustworthiness of conclusions derived from the study's multiple sources. One example was the notable lack of increase in use of referrals or identification by doctors after training, despite increased confidence in their ability to do so. This is evidenced in interviews, long interviews and survey data. Other findings (eg about GPs management decisions with couples) are supported by comparison with the literature, eg (Ferris, Norton et al. 1999) Canadian family physician population surveys about management of couples.

Additionally at the end of the study, in order to check their validity, I convened the reference group's members to discuss draft interpretations and conclusions. Members agreed that these were realistic, relevant and important issues, although there was disagreement between both GP members and others about whether GPs should undertake any couple counselling even with additional training.

3.10 Analysis

The data-gathering period extended for about 18 months from 1997/8. As I read over transcripts and listened to tapes, ideas and theories emerged about the patterns and outliers in the data. I began to keep diaries and memos in the database.

3.22.1 Checking data

I entered all data into the NUD*IST database using the sentence as the text unit. I first checked all tapes to ensure that the transcripts were accurate and make any necessary corrections. These were largely with transcripts of linguistically diverse doctors and bilingual workers whose speech patterns were unfamiliar to my transcriber, but fortunately as a former teacher of English as a Second Language, recognisable to me, even with their different pronunciation.

3.22.2 Coding

When all the new data were accurate (clean), I commenced coding. The coding process was iterative, developed from my gradual awareness of important categories, eg counselling in GP practice and pre-conceived interest in exploring variables such as gender, ethnicity/culture and location. Developing the coding framework was a long process, from categorising data types - interviews, focus groups, observations etc and then demographic data. Within demographic data, I was careful to categorise all data into gender, location and ethnicity categories (although this last is conceptually crude), so that I could follow themes according to these variables. Following this, I organised data into the three broad domains of family, general practice and training, which I determined were the most useful for conceptualising the project and the body of data. I added a specific area for each doctor and each of her/his patients (or couples) in the longitudinal interviews and one category for other interesting cases, which arose spontaneously in pre- or post-training interviews. These were for extracting patient narratives.

I maintained some free codes for conceptual categories I wished to pursue such as 'difficulties' or 'perceptions of /victims/ perpetrators/ and couples'. As these free codes developed relative meanings they were integrated into the coding hierarchy. The coding framework settled down after nine transformations (Appendix 3). At times, the coding process, in itself, seemed to fragment the data, but the relative ease of storing and retrieving data, such as the patient narratives, and the analyses possible with this technology, improved the capacity to interrogate the data. At times, in order to check the context when worried by fragmentation, I returned to the complete interview.

It was simple, with the computer-assisted analysis, to retrieve and compare different sources with each other to see whether findings were consistent (eg rural referral practices with urban practice). Retrieving reports which separated rural data from urban or eg couple counselling by gender of GP, or through 'matrices', two by two tables, allowed me to examine pre and post-training interviews by rural or urban location or topic. When I read the reports, I moved between the literature on particular issues, such as counselling and the data to consider how the data answered the research questions.

3.11 Theorising and explaining the data

When I designed this study, both the literature and the findings from my previous study suggested that gender would be a relevant factor in doctors' mode of practice with victimised women. I also assumed that patient/doctor relationships would be a site for the negotiation of power relations and that the gendered nature of these relations would be complex. These phenomena are explained by feminist theory about male power, ie patriarchy. However, as previously argued in the literature, although a gendered perspective is essential, it may not be sufficient.

Davis (1988), a feminist researcher, has argued that gender and power are inextricably linked. In her study, which comprised analysis of recorded face-to-face interactions between female patients and male doctors, she revealed how GPs 'absorbed the 'lifeworld' of patients into a medical framework, but also the ways in which this professional control was contested by patients' (Davis 1988). Patients exercised their agency with the resources that came to hand and were not passive 'cultural dopes'. GPs, she observed, did not act in patronising, manipulative ways, but in concerned, compassionate and downright 'nice' ways. Power was not being exercised in a simple or easily explicable manner. Davis concluded that gender alone could not account for the power asymmetries in medical encounters being produced, reproduced and occasionally undermined by patients. Neither could merely professional medical structures of domination account for them either. She argued that gender and power were conflated at both the macro-level of the medical structures of domination and at the micro male doctor/female patient level, still the most prevalent form of patient/doctor encounter (Davis 1988). Similarly, the GPs in this study were also concerned, committed and caring professionals. However, patterns of attitudes of some doctors to some patients suggested multiple sources of power impacting on their relationships with patients and their discourse about them. How could this be theorised and explained?

My data suggest that the doctors' disparate voices were not necessarily even consistent. Different voices from doctors' professional and gendered life-worlds appeared to be in conflict, when their professional dispositions were inadequately skilled to understand and manage intimate partner violence. Different strands of the GPs' selves were inter-woven and intersected others in the narratives. In the main, gendered patterns of behaviour were the most prominent, but I wished to find a theoretical explanation which went beyond simply arguing that doctors were socialised into gendered, medical or class-bound behavioural norms. This seemed inadequate to each doctor's unique agency and discourse and did not adequately explain the originality and complexity of ways in which these doctors practised. Similar to Davis' conclusion, gender and power were inextricably inter-linked. However so too were class, religious belief, ethnicity and other influences entangled within doctors' behaviour towards and discourse about patients.

Whilst it may not be the only possibility, Bourdieu's theory of 'habitus' was the most useful in interpreting the emergent patterns in GPs' discourse and behaviour. Habitus not only articulates the process through which people's singular behaviours and discourse develop, but offers a language with which to articulate the outcome. One can describe the unique and embodied subject, in which complex, historically bound practices are visible. In The Logic of Practice, Bourdieu theorises that through 'habitus', the active presence of past life experiences are embodied in the individual's implicit schemas of perception, thought and action (Bourdieu 1990 p54). In Bourdieu's account, 'structures do not exist separately from the knowledge we create of them and that knowledge is fluid, shifting, manipulable' (Pringle 1998). Habitus articulates the ways in which the norms of professional medicine can be modified, as Good identified, by the multiplicity of voices with which they speak (Good and Good 1993). The empathic doctor may

recognise his patient's victim-hood and see beyond her medical symptoms to the pain of incest and abuse, but if his habitus synthesises masculine, middle-class, rural Christian Anglo-Celtic family values, as Dr Peter Greenway's does, he may at times implicitly choose a messianic path to forgiveness and family reconciliation over other courses of action.

Bourdieu also identified different strategic forms of capital (social, cultural, symbolic or economic)which subjects may attain in their respective fields (Bourdieu 1990). Medicine has previously privileged its scientific base. More recently, as it has become feminised, female GPs gained cultural capital through their capacity for empathic behaviour (Pringle 1998). Consequently female Anglo-Celtic doctors may be more comfortable than their male colleagues with counselling and psychosocial issues. However, the field of medicine extracts a cost in the loss of economic and symbolic capital. While feminist theories are the most prominent and I use Bourdieu sparingly, habitus informs my understanding, analysis and explanations of the data.

In this chapter, I have presented the background, context, design, rationale and process of the data collection. Theoretical issues, research dilemmas and the strengths and limitations of the methods used have all been discussed. In the next chapter, the diversity of forms of partner abuse and the women, men and children who experience it are presented. I describe how GPs' habitus, prior to training, influence their knowledge and perception of domestic violence. I discuss how this in turn, affects their judgment of the boundaries of partner abuse and who might be suffering from it.

CHAPTER FOUR: PANDORA AND HER TROUBLESOME FAMILY – HOW GP SUBJECTS CONSTRUCTED INTIMATE PARTNER ABUSE, ITS VICTIMS AND PERPETRATORS

4.1 Introduction

To date, the overwhelming majority of research and information about domestic violence has focussed on understanding and ameliorating the suffering of female victims. Consequently, education and advice for GPs has concentrated on victimised women. In 1985, Carol Herbert pointed out that the GP may be the only professional to see all members of the family where abuse is perpetrated (Oglov 1985), however how GPs practise with all family members including children and the implications of this are poorly researched. With these potential gaps in mind, this chapter illustrates and discusses the many forms of abuse and constellations of family members (couples, women, men and children) who presented to these rural and urban GPs and how the GPs perceived and constructed them. The dilemmas associated with doctors seeing couples are illustrated and some hypotheses for why there was such a diversity of responses among doctors are discussed. New information about male patients who abuse, their health problems, men's attitudes to doctors, and doctors' to men is presented. Finally, I examine GPs attitudes to children and young people.[4]

The data in this chapter have been drawn from GP pre-training, longitudinal and specialist worker interviews. Occasionally GP perceptions and attitudes cannot be untangled from practice, so that there is some overlap with clinical practice, more fully dealt with in the next chapter. However, while there is some overlap, the emphasis remains on the GP's relationship with the patient and the GP's perception or construction of that patient. First, I explore how doctors perceive domestic violence overall, as it is pivotal to their willingness to hear or approach patients who hint or speak about the problem to them.

4.2 Hear no evil, see no evil, speak no evil - GP attitudes to working with intimate abuse

Many doctors in this study perceived working with intimate partner abuse to be difficult and unrewarding. It lacked either personal or financial satisfaction. Dealing with victimised patients required longer consultations. Often, abused patients 'do not comply' with advice, take up referrals or return for follow-up visits. Consequently, most patients did not change and therefore doctors didn't receive any *'positive feedback'*. The urban GP project manager reflected honestly that she herself didn't feel *'that I am making a difference'*. Those who did not see many abused

[4]Participant GPs whom I interviewed before and after their training are referred to first by their geographic location, then their sex and the order in which they were interviewed, ie urban male 4. Longitudinal doctors are identified by their pseudonyms. All quotes are italicised, but only longer ones are attributed.

patients spoke honestly of their reluctance to pursue it. In order for a GP to find partner abuse, you *'need to scratch the surface'* and *'go out and look for it'*.

A few female doctors regretted that the numbers of psychosocial patients they saw, including their abuse patients, skewed their practice and contributed to a lower income than their male partners.

> *You often don't want to be too good at it because you get too many of them...you might find people start referring them to you. (Dr Sally Morris)*

Overall, the female doctors believed their gender was advantageous in working with female victims because women would trust them more, they would understand the women's suffering and identify with women's experiences, but also that male patients may find it easier to speak to them about emotional issues. Most male GPs thought male patients prefer to discuss their emotional problems with female doctors also. However, female doctors believed that the stronger preferences of patients with psychosocial needs to see them came at some cost. Because they empathised with women's victimisation and identified with their suffering (and their gender position), they expressed more sadness than male doctors, more feelings of frustration and distress (that they had no 'magic' remedy) and some, consequently expressed feelings of powerlessness or demoralisation.

Some of the male doctors expressed feelings of powerlessness and frustration, for both similar and different reasons. Most expressed real concern and empathy for women's plight and frustration that they too couldn't be more professionally effective in changing women's lives. In contrast, a few worried about the impact of even raising the issue of domestic violence. As Candib suggested, this implied a value position with which they were not comfortable (Candib 1995). One GP implied that the concept was politicised, as *'a lot of groups [were] being formed to increase the awareness'*. These groups were targeted at blaming men, inducing guilt and breaking up *'partnerships'*.

These few doctors, mainly older, rural males (and other GPs) expressed frustration with the lack of clarity in the borders between acceptable and unacceptable behaviour in intimate relationships, such as shouting at your partner. The older male doctors' discourse expressed strong commitment to family preservation, guilt and shame at the behaviour of some men and disagreement with feminist standpoints, which they believed implied all men were potentially criminals. Other male doctors also expressed hostility, anger, blame and bewilderment with men who use violence. They positioned these men as 'other', to distance themselves from men who abuse.

As they accumulated, the convergence of distancing attitudes underpinned the reluctance of these GPs to actively look for partner abuse with their patients. *'I like to deal with things I can solve easily and domestic violence is one you can't'* said an urban doctor, echoing many others, *'it's like opening a can of worms'*. Metaphors about working with domestic violence expressed feelings of confusion, fear, and other threats to doctors' ontological safety.

4.2.1 The swamp of intimate abuse - GP metaphors about violence

Many doctors surveyed overseas have expressed attitudes averse to working with domestic violence (Sugg and Inui 1992). These GPs are no different. The structural barriers of time and the fee-for-service system are common barriers to quality care for many Australian GPs. This is an underlying context for GP work. Professionally, GPs perceived victimised patients as rarely rewarding and sharing many characteristics with 'heart-sink' patients - those whom doctors dread to see on their appointment books in the morning (Winefield, Murrell et al. 1994).

However, there are other more personal influences impinging on GP work. For some doctors, a lack of professional efficacy because they have not been educated about management, can lead to feelings of despair, powerlessness and more extreme feelings of profound personal threat. As many of these doctors found the problems of abuse in families generally very difficult, their metaphors of the issue evoked images of being buried or drowned, of completely losing control and being generally ontologically threatened.

Dr Errol Threadgold spoke of being '*swamped*', '*battling to keep his head above water*' and '*not being submerged*'. Dr Peter Greenway added, '*in the middle of a busy morning surgery, you've opened Pandora's box, how do you cope with that?*' He reported that his GP students, whom he trains to be aware of abuse, told him that '*it's terrifying...[they are] swamped with what do you do about it?*' Dr Jane Norton, a young, less experienced GP, spoke many times, from before the training to the very end of our interviews of facing this terrible issue. Abuse was '*ugly*', there was only *'so much you can swallow'*, it was '*difficult to unearth*', and '*quite frightening*'.

On the other hand, a doctor who had interacted with many family violence services, spoke about *lifting the lid...*

> *By hearing workers who've had more experience, family violence workers, sexual assault workers, ...and beginning to see what's underneath the lid, you sort of know what to expect...if you know that, you have a way of, I mean, people feel it's in Pandora's box, because it might overpower them and GPs loathe to come to the end of a consultation and feel that they haven't offered an effectual intervention (Rural female 13)*

Both male and female GPs' discourse grappled with the legacy of heroic scientific medicine, together with the burden of expectations implied in the title 'Doctor'. GPs spoke of battling with their own expectations of themselves as saviours. Dr Errol Threadgold's strategy was not '*having to be superman and solve the world's problems*'. Dr Jane Norton also emphasised the need *to 'strike a balance between saving the world and your sanity'*.

4.3 How forms of abuse in general practice were perceived

Doctors expressed confusion about the boundaries of partner abuse and consequently also felt uncertain about how many patients in their clinic population may have experienced the problem.

This may be the reason why so many doctors do not participate in training. Doctors, who don't see much physical violence, won't consider it an important problem for which to seek training. In addition, if they only expect to see certain symptoms and certain kinds of violence, then they will not seek different forms, as these doctors illustrated.

Doctors in this study saw an extraordinary span of one- and two-way partner violence and abuse. Appendices 1 (p226) and 2 (p265, patient narratives and summaries of all cases) illustrate the spectrum of abuse these general practitioners recounted. The varied forms of violence in GP narratives reflected many shades along a continuum of severity, from pathological terrorism (threats to kill the woman, child and her family members) to relationships where both partners verbally abused each other. The boundaries between intimate partner abuse and family violence - child, sibling, elder and carer abuse, rape and incest overlapped in some families and across generations. The patient narratives indicated doctors' difficulties in distinguishing couple conflict from partner abuse and interpreting the associations of adult partner abuse with childhood abuse and incest. Several doctors spoke about violence being the norm in some families with whom they have worked. Some were aware that women in such situations might normalise the abuse.

Some doctors believed referral agencies did not see such a continuum:

> *CASA and the police force and the crisis line are dealing with people at one end of the extreme, and in general practice...it's not a black and white area, you see shades of black. (Dr Jane Norton)*

Dr Norton's practice partner was aware of the complexity of general practice cases and cautioned that patients were difficult to pigeonhole:

> *I don't believe it's easy to break people up into victims and perpetrators, I think it's a lot more complicated than that...I don't think you can be black and white in a grey, grey world. (Rural male 7)*

Many definitions of domestic violence, particularly those in the criminal justice system, tend to stress physical violence only, so it is not surprising that the doctors were confused about its conceptual boundaries. The GPs' notions of prevalence depended on their perceptions of these boundaries. The confusion about definitions was compounded by popular perceptions (that all victims look like classic 'battered women', ie severely abused). Legal definitions were entangled with individual doctors' personal attitudes to the relative importance of the problem and consequently affected what they sought to identify.

Before they undertook any education, I asked doctors about their perceptions of domestic violence prevalence in their practice population. The most common perception was that the prevalence in their practices was higher than they identified. It was quite common for these doctors to express some guilt and feelings of inadequacy about not seeing more:

Probably three or four have fessed up...that's not very many, and I think there's heaps of them. (Rural female 11)

But there was a wide range, depending on whether doctors understood partner abuse to be only physical violence. The two doctors below illustrate such perceptions. Both were only looking for women with injuries:

In a year, about three or four...There might be a lot more, but it was difficult, at least with the Sri Lankans and South Americans and the Vietnamese people, you can see their body, but with the Turkish and Arabic people you can't see their body. (Urban male 1)

This led the second to disbelieve the prevalence rates, as he did not identify many victims:

The figures they say, one in four women and one in six men have had some domestic violence in the past. They seem to be extraordinary. (Dr Harold Rosario)

Rural GPs stressed emotional abuse much more commonly than their urban colleagues. One rural female GP spoke of a continuum of abuse from emotional abuse to murder. Many female GPs spoke of the primacy of emotional abuse in women's lives.

When some of the patients divulge, it's because there's been specifically violent events and they just feel they can't deal with that any more. But to be in that situation they're often subject to emotional abuse and neglect on a daily basis. (Rural female 1)

Dr Rosalie McLeish expressed considerable uncertainty about the boundaries of what she was seeing, and asked about a couple she was currently counselling, *'there was emotional violence on both sides...there really wasn't physical violence if you have to actually hit the other person, or was throwing things counting? Does that count?'*

Other doctors included a wider range of behaviours and some consequent high rates of identification. They freely elaborated how they distinguished what they saw:

Out of every ten cases of abuse, I'm finding in this practice one of violence, nine of [childhood] sexual abuse. It's just that more common ...verbal abuse would be frequent...probably one or two new cases a month...I'm not talking about flying off the handle in a temper. I'm talking about a repeated abuse, which was having an effect on the psyche of the other partner. Either in terms of fear...or leading them to self-denigration or even self-mutilation. I find that a vastly bigger problem than physical... and it's 99% of them would be male versus female. (Dr Peter Greenway)

I see a fair bit, but I think I'm getting the tip of the iceberg...I've got three patients who are being stalked, I have three of my regulars, who are in very abusive relationships and have chosen to stay in them, and I would see them fairly regularly...In a three month period...probably maybe about 5 to 8. (Dr Jill McPherson).

Without expertise, other influences within their habitus, the unique blend of an individual doctor's lived experiences, informed doctors' perceptions of partner abuse. Some GPs' perceptions of abuse were not necessarily consistent from patient to patient. For example, Dr Peter Greenway is an empathic Anglo-Saxon rural gentleman farmer-doctor, originally from England, whose narratives were sprinkled with *'devotion', 'dedication'* and *'forgiveness'*. He often repeated a litany about sacrificing one or two evenings a week to counselling for his community. Dr Greenway has uncovered several major cases of adult survivors of child abuse. He has a heightened sense of awareness about the issue and is justifiably proud of his victim/survivors' recoveries. He spoke strongly about his genuine commitment to his rural community. Dr Greenway initially conceptualised the major problem in rural partner abuse as a form of psychological abuse where women are subjected to being *'called an eff'ing c*** every day for five years'* and stressed that rural GPs like himself, didn't see much domestic violence (ie physical abuse). His habitus, expressed in language with obvious Christian, even messianic references, implicitly guided the following professional judgments.

Sophia, his 17 year old Italian female patient (Appendix 1, No.1.2), was molested by her grandfather and father's friend. In his narrative of her story, Dr Greenway minimised her mother's and her own physical abuse and threats from her father. He firmly believed in the need for family cohesion in the country and that the problem in her case was neither her father's threats of violence nor her abuse, but her father's intransigence in not believing her story. He sought special permission to breach an Intervention Order, not mentioned in an earlier interview, to bring Sophia and her father together to effect reconciliation. He played down the violence outlined in the order as not *'heavy violence, in the sense of being beaten up'*. He chose in this instance to focus on family reconciliation rather than family violence. With Dr Greenway's encouragement, Sophia briefly reconciled with her father, then returned to her mother, who had separated from her father.

In the second case, Amanda (Appendix 1, No.1.1), a middle class female patient and church friend of Dr Greenway's mother, was hesitantly presented as a perpetrator. She fought with her husband when she was drunk. It emerged that she was a childhood victim of extreme sexual abuse from her father. Again, Dr Greenway emphasised the importance of rural family preservation and his belief in the need for Amanda to forgive her father.

In a further example, a consciousness of economic disadvantage led one GP to a heightened awareness of financial abuse. Dr McLeish was an empathic rural GP, so her colleagues referred many psychosocial cases to her. She counselled many patients and because she was not vocationally registered, was financially disadvantaged. She was always running overtime and, as a single woman, had no one with whom to share the financial or emotional burdens. She had financial problems herself, and understood poverty. She was the only GP who detected financial abuse and from this other forms of abuse.

I don't normally sit down and go through somebody's finances, but...we just sat and talked about things... she wasn't getting enough money to survive...[After the patient's court case] she wasn't allowed access to the car, to the phone, she couldn't get out of the house because she couldn't get access to the keys. I didn't realise how severe it was.

As I outlined above, the lack of professional skills left these doctors feeling powerless. At times, similar to Davis' perceptions, doctors could reconstruct partner abuse sequelae into symptoms managed more easily as medical problems (Davis 1988). These could be one partner's medical symptoms, such as an eating disorder or psychiatric disability or alternatively, marital problems. This often occurred when women either felt unable or didn't want to leave. Rural male 7, an experienced rural doctor, spoke of ten to twenty cyclically abusive cases in his patient population as '*fairly stable relationships*', a gender-neutral term, which were those he '*keeps his eye on*'. He was Dr Jane Norton's senior colleague, who also spoke of women perceiving domestic violence as a relationship issue.

If physical abuse was intermittent, any other form of coercion or controlling behaviour may be overlooked or minimised. Dr Norton's patient Mrs Davis (Appendix 1, No 2.4) was married to a manic depressive man, who beat her when he took himself off medication. Mrs Davis blamed her weight. Mrs Davis' husband also abused her financially and psychologically, but the physical abuse and the eating disorder were Dr Norton's major focus. While empathising and supporting her, Dr Norton referred Mrs Davis to an eating disorder clinic, but was unable to manage the abuse, which was minimised.

Dr Errol Threadgold reframed partner abuse as marital problems when women chose not to leave. He did understand some of the structural barriers for women and elaborated on many couple cases where women did not leave:

It's like any other thing about marriage that you've got to take the good with the bad. And if once every three months you get hit, but the rest of the time is reasonable, well they put up with that, because the options of being a single mother or of going out in the community by yourself aren't there. And a lot of women...still love their husbands despite that and they don't want to leave. And that then would suggest that you've got a relationship problem, rather than a physical abuse problem. (Dr Errol Threadgold).

In summary, prior to partner abuse education, the study doctors perceived abuse according to the patterns of their existing beliefs and experiences, their habitus. Structural and emotional barriers could sometimes prevent them wishing to see abuse at all. Similar to those in the wider community, some doctors perceived physical abuse alone or, more often in rural cases, emotional abuse, although some doctors expressed difficulty knowing where the boundaries lay. However, concepts of partner abuse were not always stable and personal beliefs could be influential in constructing the problems for some patients differently. A few doctors could articulate the many

different forms of abuse they saw. Other doctors were less familiar with the different manifestations partner abuse might take or when power imbalances between partners affected the two-way violence some partners presented. Consequently, some study doctors had no language with which to frame the differences in couples they saw, or the domestic violence they perceived. As they had not been trained to be professionally effective, they reconstructed their patients' situations into medically comprehensible terms, so that intimate partner abuse could easily be marginalised or normalised. Most, but not all these doctors believed there was more partner abuse in their patient populations than they were identifying.

The study doctors were more likely to overlook or minimise abuse when they were seeing both partners in the family. If a woman felt unable to leave, doctors could collude with the male partner, feel frustrated with her and at times jeopardised her safety, as many doctors saw patients as couples.

4.4 Seeing couples

Understandably, GPs placed great value on the doctor-patient relationship. When doctors saw both partners of a couple – their 'dual relationship' (Ferris, Norton et al. 1997) – ie their relationship with the couple could influence their marginalisation of violence, their emphasis on couple preservation or to prioritising the needs of one partner, depending on how partners were perceived.

The following examples of patterns of couple perceptions and consequent practice derived from GP and specialist worker interviews, narratives and the literature. The first pattern is that of breaking confidentiality.

4.4.1 Breaking confidentiality (the possibility of iatrogenic violence).

As evidenced in other studies, however well-intentioned doctors were, there were occasions when seeing couples that they broke confidentiality, which could lead to women being beaten for betraying confidences (Bowker and Maurer 1987; Head and Taft 1995). Without knowledge of the different types of men who abuse, GPs can find it difficult to perceive the charming male partner, perhaps friend, as a perpetrator. The rural domestic violence worker illustrated this from among her local clients:

> *I had a doctor ring me when a woman went there and disclosed to the doctor and...the doctor took it upon himself to ring the partner and challenge him over what had been said.*
>
> *Q: Did he ask the woman's permission?*
>
> *No and he rang him and said to him this was what's been put to me today, I can't believe it. You've been coming into my surgery and we knew one another from Rotary and... she just got the biggest hiding you've ever seen in your life when she got home and of course she didn't go back to the doctor... She wasn't going to go back and say he's done it again.*

Dr Jill McPherson had placed great value on her relationship with both partners in a couple. Although it was unclear whether further violence was the outcome, Dr McPherson described in Appendix 1, No 6.2, the lesson she learnt when consulting with a Maltese man whose wife had disclosed that he was cyclically violent after she inquired about some bruising. She reflected on the dangers of close patient/doctor relationships:

> *I'd been seeing them both for a long period of time and had developed quite a rapport, there was a shared sense of humour and we often had tales, you know, you probably shouldn't be going so far along that line in consultations but we had a set of things that we enjoyed talking about.*

She had mistaken her female patient's depression for homesickness. She didn't ask the wife's permission to talk to her husband, but seized the moment when he came in for a check-up. When he guessed his wife had disclosed, he stormed out of the clinic and went home. Dr McPherson phoned to warn her, but he arrived and slammed the phone down. She never saw them again and sought counselling herself for the associated trauma. Dr McPherson used this experience to warn others in the urban project of such dangers. Dr Errol Threadgold mentioned that this had also happened to him, as did a few other doctors.

4.4.2 Only seeing the violence when it reaches crisis.

In similar ways, nurturing a closeness with 'the family' could also lead to overlooking abusive or coercive behaviours if physical violence was not obvious. Dr Peter Greenway emphasised his closeness to the Greens (Appendix 1, No.1.3) and their loyalty. He described his ten-year relationship with Mr and Mrs Green as:

> *An extremely happy and friendly relationship...both Mr. and Mrs. Green know me well and would most very definitely mention me as their doctor, or the person to contact in a medical sense.... So if they haven't come to me, it's most unlikely that they've gone somewhere else.*

Mrs. Green, a diabetic, had attended regularly with her small children. She suffered from chronic migraines, a common symptom in women experiencing abuse. Mr. Green attended for back pain associated with a workers' compensation claim. He seemed to have suffered a breakdown, for which Dr Greenway commenced counselling. Dr Greenway was concerned about Mr Green being possibly suicidal and homicidal - however, it was only when Mr. Green threatened his wife and himself with rifles that the underlying situation became more clear. Dr. Greenway's comment that Mr. Green '*didn't actually hit his wife*', despite terrorising her with guns and vandalising the house, suggested that he may have been unaware of a considerable number of previous abuses. It was unlikely that with Mr. Green's military background, gun ownership, depression (and back pain) and Mrs. Green's symptoms, their poverty and young family, the abuse simply flared once at the end of the relationship. Despite Dr Greenway's awareness of incest and emotional abuse, it

was likely that lack of knowledge of the extent of partner abuse, his relationship with both the Greens and his focus on Mr. Green affected his detection of potential abuse in this family.

4.4.3 The potential for victim-blaming when treating couples

Doctors may not only exhibit victim-blaming of patients who are partners in a couple, but there was a clear tendency for some GPs to do so. Because vocational training has not prepared doctors to comprehend the effects of chronic abuse or issues of gender and power in intimate relationships, some participating doctors allocated blame and responsibility within the couple, from identification with or marginalisation of one or other partner. The following examples illustrate the potential for doctors to take sides within couples and to divide women into 'deserving' and 'undeserving' victims', when they were seeing both partners. The two male doctors revealed in their discursive narratives, identification and collusion with male partners merged with religious and class attitudes.

There is two-way partner violence in the first example. The power balance between the couple was unclear, but the unsatisfactory lack of progress for both GP and patients was more obvious. The effect of Andrea's loudness and externalisation of anger are the focus of Dr Threadgold's medical attention and frustration. Her male partner Jack is sympathised with and never referred for treatment for his violence.

Jack and Andrea (Appendix 1, No.7.1) had been attending Dr Errol Threadgold's clinic for a number of years. Jack was an unemployed white New Zealand ex-truck-driver and Andrea (Anglo-Australian) was at home with the four children. They were clearly poor. Jack didn't help around the house. Andrea had been taking tranquillisers for many years, which Jack occasionally requested for her and to which Dr Threadgold readily acceded. Both partners abused alcohol and amphetamines. Dr Threadgold spoke about:

> *...The difficulties of managing both husband and wife, I think it does present a real dilemma for people. Because I find myself often siding on one side, and tending to therefore counsel from one person's perspective over the other. And I frequently as you probably gathered, take the woman's side.*

In spite of Dr. Threadgold's self-perceptions, he sided with Jack. In his narrative of Andrea, he described her as:

> *Not terribly insightful...got a motor mouth, which was thrown into gear before you open the mouth... she just reacts... When Jack was not on drugs or booze he's a very clever man to talk to and ...has a bit more insight into things when he's got time to relax and think about it.*

Dr Threadgold described Jack as losing his temper, but he said he was not sure who was more responsible as:

> *Once it turns violent, they're both into it...She's physically violent to him because he hasn't done a great deal...she's admitted it, she's said, yeah, sometimes I'm a real bitch...and I've actually said, I don't think that's really fair because he's got a few problems to put up with.*

Dr Threadgold was frustrated with his inability to persuade Andrea (rather than Jack) to change. He alternately blamed her for coming at the 'wrong' times, manipulating the clinic by seeing different doctors and fighting back. Andrea's anger needed medication. Dr Threadgold maintained her for a long time on tranquillisers. He observed: *I think the quieter Andrea gets, the better the system runs. When she's under control, everything else seems to fit in and go under control.* Thus Andrea's anger was the focus for 'control'.

Dr Threadgold reviewed Andrea's files in our interviews and described many potential symptoms of childhood sexual abuse (unresolved chronic gynaecological problems, IBS). She was raped by another truck-driver during the narrative period. Dr Threadgold had not asked about childhood abuse and he observed:

> *It's interesting, when you start to talk about it like this; you begin to wonder whether you're missing a whole lot of things.*

He then speculated about Jack's potential abuse of his children. He did consider that tranquillisers weren't a satisfactory long term strategy, but Andrea wouldn't agree to couple counselling, at which point he argued that she wasn't motivated to long term change. His explanation was:

> *I don't think things really change a great deal for those people. I think, I've often thought there's a group who do not understand intellectually these problems, and they can't do that sort of process. I've often thought that's why they're blue-collar workers, that they're not thinkers they're doers, they just use their hands.*

Andrea in fact separated from Jack, took herself off tranquillisers, moved to the country and reported herself to be much happier.

In a set of contrasting examples (both with severe forms of chronic abuse) Dr Harold Rosario, a solo GP, narrated stories of two couples from his own NESB community. In his discourse, tensions between moral and social condemnation of Mr Mizzi and moral and religious approval and concern for his wife surfaced between Dr Rosario's actions to help her. On the other hand, Mrs Starelli's non-compliant, rebellious and verbally aggressive behaviour drew discourses of disapproval from Dr Rosario and identification with Mr Starelli, although he tried to help both partners.

Dr Rosario was fond of and had known Mrs. Mizzi (Appendix 1, No.5.3), a nurse, since her childhood (he had been her school teacher) and condemned the behaviour of Mr. Mizzi, who was illiterate and who emotionally and sexually abused and possibly raped his wife. He beat and emotionally abused his sons. Mrs Mizzi was a devout Catholic, as was Dr Rosario. She resisted

pressure to divorce her husband, a suggestion made by a hospital social worker when she had treatment for her epilepsy. Dr Rosario was very supportive of Mrs. Mizzi's dilemmas and has made several attempts to contact her clandestinely in order to offer her information and support. She was perceived as a 'good' victim. She did not divorce and was morally superior to her abusive and illiterate husband.

In contrast, Dr Rosario gave a very different description of the Starellis (Appendix 1, No.5.1). Mr Starelli regularly physically and sexually assaulted his wife. Mrs Starelli went out to work in spite of her husband's wishes (he fixed cars at home on the 'black market'). He was concerned his disability pension might be reduced. He was on a pension for both chronic heart and back problems. His wife had frequently attended Dr Rosario after she was beaten and she has also called the police. Dr Rosario has unsuccessfully tried couple counselling with them.

> *It's amazing, these two people, they both come to me, they come to the same person, and both of them, from very different angles and yet expect advice which was applicable to their own particular case. It's very funny, because normally you go to different persons.*

Dr Rosario described Mrs Starelli as a nagger, provocative and verbally aggressive. He spoke as a fellow husband, sympathising with Mr Starelli: '*actually I feel for him, because I know what he's going through. She's not the only one who's suffering*'. Dr Rosario then minimised the violence towards her: '*they clash…because when he hits her, he's just in a fit of anger, he's not aiming to kill her, but...because in a way now, she does set him up. She uses words in such a way to taunt him.*' He was at pains to say that she need not obey, but that he:

> *Wouldn't like to live with her, as she is provocative...and then when she is hit, she starts stammering and crying. I'm not saying that she deserves to be hit, what I'm saying is that there is some provocation, and some people can't take that.*

Dr Rosario reported how he asked Mrs Starelli why she provoked her husband, but it was not clear whether she perceived these remarks to be judgmental and unsupportive. Dr Rosario has warned Mr Starelli that his behaviour was criminal and he may end up in gaol. He tried to help both people individually, but his attitude to Mrs Starelli is at the very least unhelpful.

4.4.4 Marginalising the abuse

In seeing couples where women appear not to be able to effect change and men take no responsibility for change, medical problems can be given precedence and doctors can marginalise the abuse. A case in point was Dr. Threadgold's patient Helen (Appendix 2, No.2.14) a nurse in her late 40s, married for nearly twenty years to an alcoholic and abusive husband. Recently her partner Bob had been admitted to hospital with acute liver failure. Dr Threadgold reported that Helen had threatened to kill him one day, although he was 'sure' she wouldn't. Dr Threadgold has spoken to Helen about separation, but she hasn't the strength to leave him.

She always said that if he stopped the grog things would be all right. Now I don't know whether he'll stay off, but he, we gave him a fright a while ago with cigarettes, and he just stopped them, you know, like that.

Given Bob's ability to exercise a powerful level of control over his smoking behaviour, I asked whether Dr Threadgold had ever spoken to Bob about his violence? In his reply, it is clear that looking after Bob's health was the priority, rather than Bob's abuse of Helen and their children:

Umm, no, not ... umm, not that I can think of. I would imagine the way the consultation goes, he'd just deny it - not me. He's one of these blokes that has an ability to make a sort of a joke of things and just slip it off...I presume it must be obvious to him, because none of the kids live at home. Or moved out because of his behaviour. And again I haven't ... it doesn't seem right to do it at the moment, because he's behaving himself at the moment. And I don't think, why bring up a new critical aspect to his life while he's staying off the grog and looking after his health.

In summary, these doctors were seeing a proportion of their patients experiencing abuse within couples. There are several ways in which these GPs could construct victims and perpetrators in couples or miss the abuse completely. First was the pre-eminent value placed on the doctor-patient relationship with the couple. GPs could use their access to both partners to speak to male partners without the female partner's consent, at the risk of breaking confidentiality. Next, if GPs perceived the couple as a unit, they may overlook partner abuse, until the couple was in crisis. Third, from within their habitus, doctors conceived patients as 'deserving' or 'undeserving' victims or perpetrators. The implicit attitudes and beliefs they then brought into the consultation influenced their choices of management with their patients.

Part of the dilemma about working with couples seemed to be overall GP attitudes to men who use violence. Very little has been written about these men, other than psychological profiles of individuals in clinical sub-samples or socio-demographic profiles from evaluation of behaviour change groups. The great majority of doctors would not have read any of this information and have no informed advice about working with the range of men who may abuse. It is likely a wider profile of men who abuse attend GPs, compared with those in clinical samples, but GPs may only perceive those who fit popular stereotypes, eg working class aggressive men. While Owen, a man from the focus groups with abusive men, was a tertiary educated professional, there were no GP narratives of middle class men, where there were of middle class women.

4.5 Men who abuse partners

In the following section, I present information from the GPs' patient populations about the spectrum of men who presented to them and about whom they chose to speak. While we can learn a lot about abuser behaviour from women's stories, men also present directly to GPs, either with their female partners or separately. There are narratives about twenty men in the longitudinal case

study interviews and about men in general in other participant GP accounts. These men are those most visible to the doctors. Male patients varied in doctors' narratives from the pathological terrorist to the guilt-stricken depressive and the verbally abusive. I describe doctors' attitudes to men who abuse. In order to flesh out GPs' accounts, in this section I also present data from educators, workers with men and men themselves, about their health experiences and behaviours. The important issue is that men were visible in GP accounts.

GPs have not been trained to distinguish among the different types of men who abuse nor be aware that abusive men can be charming in public. Having developed empathic patient/doctor relationships, the doctors found it difficult to reconstruct 'nice' male patients as abusers. One GP described her difficulty when male partners were charming in the consultation, but not at home:

> *I think it's hard to think of some of the men as perpetrators if you've been caring for them in other ways and really had no suspicion. I also think there's a tendency to minimise the violence and reassure yourself and the woman that, oh you know, it's just bad temper or something like that. (Urban female 7)*

4.5.1 The health problems of men who abuse

Doctors described the health problems of male patients who abused which were common in the literature: depression, alcohol and drug problems and childhood abuse. Almost all abusive male patients were aged between their twenties and fifties. Most men visible in these narratives were poor and many were unemployed at some time. Some were from non-English speaking communities and one young man was from a Koori (indigenous Victorian) background. The majority had children. A few had stepchildren.

Doctors reported that eight men had problems with alcohol, six expressed suicidal ideation, and four had florid psychiatric symptoms (Mr Connor's and Mr Davis' manic depression, Mr. Green and Mr. Ahmed both suffered breakdowns). Mr Green and Mr. Connor had mutilated themselves. Two men were reported as abusing their medication and illicit drugs - Mr. Ahmed overdosed his anti-depressant medication and his pain-killers, both Jack and Mick, the Eastern European man (Appendix 2 – Dr Threadgold) abused these and also amphetamines.

Alcohol and drugs also featured prominently in stories from men in the abuser group. These men spoke about themselves and other men in the male behaviour change groups:

> *There's a few that get right off their face on marijuana, but when they're off it they're frigging crazy, they want to punch the shit out of anyone. (Barry)*

> *My experience was that you tend to have a smoke... you don't do it in public, you're doing it in a very small group [and] you're less likely to become violent... the lads go out and get a skinful of beer or spirits and that's when they do their abuse. (Owen)*

When I got to AA, I was sober nearly three years and a lot of the stuff was about making change...and it wasn't until I picked up my wife by the throat and I put her down immediately and that really pricked my conscience, because I was still doing the same things now as I was doing when I was drunk, and I couldn't remember it when I was drunk. (Rick)

The majority of male patients in the GP narratives had medical problems to present to the doctor. Depression, stress, pain related to back and other injuries, headaches and insomnia were common in GP narrative accounts. One GP mentioned problem gambling.

Specialist workers with men stressed tension related problems in the groups of men with whom they worked, so that as well as drugs and alcohol (particularly binge drinking), they spoke of 'pain syndrome', high blood pressure, migraines, insomnia and gastro-intestinal problems. One worker conceptualised several problems: problem drinking; drugs; suicidal ideation; and self-mutilation as *'any sort of self abuse'*, as those in which GPs should suspect the man's abuse of others as a possibility.

Back problems (most associated with workers' compensation) are not mentioned anywhere in the literature, but were reported in seven out of twenty male patients. It was not surprising to find these in Dr Errol Threadgold's and Dr. Jill McPherson's cases, as Dr Threadgold works in a clinic which specialises in workers' compensation cases and both GPs work in an industrial blue collar area. However, Dr Harold Rosario and Dr Greenway did not and yet their patients Mr Starelli and Mr. Green presented with workers' compensation related to back injuries. As I was struck by the frequency in doctor's narratives, I asked the men who were former abusers, about back problems. All four, unbeknownst to the others, had experienced back problems.

A lot of the guys who come here [to the groups] have got back injuries. I reckon I knew ten last year and it surprised me. (Barry)

I collapsed at work one night, my legs just wouldn't carry me. They took me down to the local clinic and they couldn't find anything wrong, so they sent me to F Hospital and I stayed the night there. But I knew what it was, just stress, because that's where it hits me, in the back. (Rod)*

The men from the abuser group reported their other health-related problems. Owen spoke of his workaholism (also referred to by specialist workers) to avoid the problems in his relationships. These men reported that road rage was also quite common among their group members. Rod spoke of his own breakdown, Rick of his father's breakdown. Barry, the abuser consultant to both training projects, spoke about his chronic violence and stress-related symptoms, his doctors' constant misdiagnoses and the cost to the health system:

I used to go the doctor all the time with stomach upset, still do, ... they've stuffed things down me stomach, up me bum, in me ears, everywhere. They can't find nothing wrong. But it always happens when I get stressed... Headaches, diarrhoea, heart attacks ... I've never had a heart attack, but I reckoned I had about five hundred. They got sick of seeing me, fair dinkum, they had the shits with me chronic. And that was all stress-related. (Barry)

Men who abused appeared to suffer from wide-ranging ill-health problems associated with stress, from back and other pain to forms of self-abuse, which might have led to the abuse of others closest to them or extended to workmates and strangers. Many GPs were aware of the stress-related symptoms such as depression, alcohol and drug addiction. The frequency of back-related problems has not been noted elsewhere, or its relationship with workers' compensation claims.

4.5.2 Men's help-seeking behaviour

Many doctors, particularly female GPs, reported anecdotally that a growing number of men were presenting to them in general, but most GPs said that men would rarely present explicitly for help for violence. In the longitudinal case interviews, more female than male GPs discussed male patients who spoke of their abuse.

Specialist workers with men and male educators spoke of a growing number of men who abuse seeking help from them, often sent by their female partners, who had threatened to leave (they referred to these men as 'wife mandated'), or because wives had already left. Workers reported that because more men were seeking help as women became less tolerant of abuse, men's behaviour change groups were mushrooming.

Of the twenty male patients whose consultations are summarised in Appendix 1, seven came to GPs because their partners had left or threatened to leave them. The remaining men presented to GPs for their physical and psychosomatic problems. In contrast, while Jack attended Dr Errol Threadgold for his own health problems, he also came to see that Andrea was kept under control. In this quote, Dr Threadgold spoke of Jack's initiative to control Andrea, but his own actions colluded with Jack's.

He's come in ... they often come in together, but he has come in separately. And he'll say, look, you know, I can't stand this, she's flying off the handle, she's uptight, give her the pills, Doc, to calm her down, sort of thing. And you can tell that it's a very suppressive sort of approach to it, that if you take a pill and she calms down then everything will be all right.

Men in the abuser focus group reflected on why they did not seek help for the stress associated with abuse sooner. Each had very different attitudes to doctors from fear and loathing to complete dependence:

> *My belief at the time was that if I told somebody else about the problems I was experiencing, then I believed that would be giving that person ammunition to use against me later...when I was a kid... we never talked about feelings...If we did, then you were considered weak. (Rick)*

Rick had hated the impact medication had on his father when he had a breakdown and one of Rick's children had died in hospital. These experiences had put him off doctors. He felt that previously doctors would have been judgmental about men with drug and alcohol problems and was pleased that it was now regarded as a *disease.*

Rod was a very dependent and controlling person. He went to the doctor often but always with his wife. He still does. He never allows his wife to attend the doctor without him, but he rationalises: '*This is my wife, I've been with her for 18 years, no-one's going to tell me 'walk away'.* He further explained:

> *When my wife and I had our upheaval [sic - and she threatened to leave him], I never thought to go and speak to my doctor about that. She advised me to go and see a psychologist, my wife did and I came up here [to the CHC]...I've got a very good doctor... and since he's known about me coming to the men's group, he's been very supportive to my wife and I...Like my wife and I look upon Dr. K as a family doctor and he's responding like a family doctor, which is helping us too.*

Rod is pleased that his GP treated him respectfully and supported his efforts to change his behaviour, while not threatening the partnership. In contrast to the support Rod received, Owen expressed attitudes similar to many female victims about the medicalisation of stress. He reflected on his experiences:

> *They don't listen. All they're going to do is prescribe some pills...I would have been too ignorant to realise I had a problem with violence. I would have thought there was a catalyst and there was reaction and for me at the time it was over and I felt bad for what I did, but I didn't see it at the time for what I know now is a violent and abusive personality.*

Barry calls himself a '*doctorholic...if I've got an injury or I feel sick, I'll go to the doctors like a flash'.* He didn't previously perceive doctors could be anything other than biomedical:

> *Now, I'd say, yes, I have an illness, but in them days, I would have said no, that's not an illness [stress and abuse] Doctors just sew my knee up when I cut it, it's not his job to get in my brain.*

He spoke of only reaching out in crisis. He had been to the hospital where he was confronted with domestic violence posters which, while making him feel bad, didn't catalyse any helpseeking. He only acted in crisis:

When the shit's really hitting the fan and when I have to, I have to, but until then I don't seem to seek it...and blokes, everyone's different...like me, I had to be belted around the head with it.

He then described his final step to seek effective help, including his choice and reason for the sex of his psychologist:

One day it was just all bad so I had to do something [he was afraid he'd murder his wife], so I ...rang up a psychologist, a woman psychologist, because I was too shit frightened to tell a bloke... I just opened up the phone book and said I've got to do something...and I scared shit out of her and she referred me here [to the men's group].

It took five returns to the group before he changed effectively. His transition to less abusive behaviour took six years and he still attends for reinforcement. He hasn't told either of his GPs of his abuse or his work in men's groups, neither have Rick nor Owen. And the GPs haven't asked.

These men's attitudes to doctors ranged from fear and hostility to control and dependence. However, three of the four attended their family doctors regularly. They received medication for symptoms which were the result of their angry and aggressive feelings and behaviour, and which could be costly to the health system. Only one (Rod) has told the doctor about his problems and attempted change and has received support from him.

4.6 GP perceptions of men's presentations and abuse

Doctors spoke generally about the difficulties of discussing emotional issues with men or getting them to come for 'counselling'. No doctor had previously received education about working with men who abuse. In agreement with the testimony of men who have abused, many GPs discussed the difficulties of successfully challenging men to disclose, believing that even when they did discuss their 'anger' problems, men did not want to disclose the level of their violence or take responsibility for it.

I have to handle the effects of it, but I don't handle the perpetrators of it. Because [pause] I'm a GP. Nobody but nobody comes and sits where you're sitting and says, I've just belted up my wife. (Urban male 4)

I've had one, possibly two actually disclosing, most of them have come in angry at their partner and that when you suss them out and you basically say, you've got a problem, they don't like hearing that very much. (Urban male GP educator)

I've got four at the moment who would talk to me about the fact that they've got anger problems, was the way they talk about it. One of them quite bluntly says, oh I can't seem to stop myself, you know, I've just got to hit someone and it will be her. (Dr. Jill McPherson)

One empathic but stressed GP, who had read popular texts on men and masculinities (Bly 1992; Biddulph 1995) attended training because he felt he wanted to work on masculinity issues with men and boys. He expressed a tension between his need not to reconstruct his patient/doctor relationship with male patients with his desire to treat aggressive men and the difficulty with it. Although he saw men's anger, he did not 'see' many victims. His vacillation surfaced in discomfort:

> *I also see a lot of men that have anger problems, I don't know whether I'm actually seeing the result...I probably don't see the domestic violence because people who come in here, I think are just nice people...the majority of people with anger problems have anger that I pick up that they don't perceive as being a problem. (Urban male 14)*

Some GPs spoke of men presenting with a physical problem, before they then moved to the issue really troubling them:

> *The ones that end up being counselled often present with a physical problem, but are quite distressed. You tease out of them quite quickly that its other problems that are bringing them there...I saw someone yesterday who presented because he'd broken his right hand and he wanted an x-ray for it...He'd punched corrugated iron and he also wanted to check because he's had slurred speech problems with a severe motor car accident when he'd been drink driving...He was really worried about his temper and his partner [and her baby] was in refuge. (Dr Jane Norton)*

> *They come and say they are not well and if you keep on asking how do you feel, they admit they are feeling angry... It's usually anti-depressants they need. I have two or three people who are very, very angry. They came to me, the men only, the females don't come and they were saying that they were very angry in the house. (Urban male 1)*

In the above example, anger and depression are identified but anti-depressants suggested as the only treatment. However, other GPs who preferred to offer counselling, believed that even if men did disclose, they were unwilling to do anything about it:

> *I see plenty of blokes. I don't have many that complain of it. I know many suffer from stress, hypertension or just have symptoms and they're under stress. But you've got to talk to a dozen before you might get one who might actually act on it and come back for further counselling. (Urban male 5)*

A few male doctors believed that men may attend them for physical problems but would go to female doctors for emotional problems:

> *My observation was that if men want to go and see a doctor, I've noticed they tend to go for the sort of blokey type stuff to the girls...I think that a bloke in trouble finds it easier to open*

his heart up to a woman than to another bloke...he's worried that another bloke might think, you're a bloody wuss, get on with your life. (Dr Peter Greenway)

If they have got colds and coughs and chest pain, they don't mind coming to me, but if it's a personal problem I think they want to go to a lady doctor (Urban male 1)

Others believed that men would only present if 'wife mandated'.

One of the patterns that occurs was that they will come along when they have provoked a sufficiently great crisis in their lives that its safe to appear to be going to ask for help. Like the wife's finally left. (Dr Peter Greenway)

The abusive men come where the relationship was still going well and the person was reasonable and [then he] suddenly wakes [to the fact] that he what he is doing [is going to threaten his relationship], ...and then he wants to keep the marriage going. (Urban male 11)

Some doctors ascribed the difficulties they had with men, as they did with some female patients, to the belief that the men don't change. Some believed that they couldn't change, so women should leave.

My only gut response was that these blokes were never going to change and the best thing a woman could do was get a million miles away from them. (Rural female 11)

More than the belief that men wouldn't change, a few GPs expressed the view that such men are born this way. The paediatric trainer was taken aback by this:

The idea that violence was inherited and you can't do anything about it, it's innate... and therefore that's the way life is, bad luck, can't change it... that certainly wasn't an opinion I was expecting. (Paediatric trainer)

One specialist worker with men stated that some of the men also believed this, which meant that they did not need to take any responsibility for change, as there was no point. If a doctor reinforced this view for men, it was a reason for men not to consider behaviour change:

Some times the men think that you are actually born violent...that can sometimes be quite a powerful value for people...others think you're born that way. (Female domestic violence worker with men)

For Dr Harold Rosario, the ways some men behaved were a scientific mystery, a disease as yet unsolved:

There is a phenomenon of some men...who are like wolves in sheep's clothing. They are wolves at home, but everywhere else they are timid, they will...go to the end of the world for

you, but in their family life they stand stiff and authoritarian, to the extent of abusing, physically or verbally. It must be some kind of medical syndrome without a name to it.

The response from some doctors to men who abuse expressed fear of them and possibly also stereotyping:

Deep down, I was probably a bit frightened of these blokes...I just thought they were arseholes a lot of them...and on a dark night I'd probably run over them. (Rural male 14)

Whilst others empathised, perhaps even identified and were not afraid of them:

I have a very violent temper, I've only ever had to show that temper three or four times. Each time it has been an overwhelming and extremely uncomfortable experience...but fortunately I never injure anyone. But I can imagine what it would be like to lose that control. So to me, they're not monsters. I don't find them sick, I just find them as people who've the misfortune they're not able to control that anger. (Rural male 7)

Despite seeing diverse men in their patient populations, some GPs expressed stereotyped beliefs that other men's abusive behaviours were those of 'other' cultures:

*Some Maltese from A*** who's beaten the shit out of his wife... because he doesn't see what he did wrong, because women are just there to do what he bloody says. (Dr Peter Greenway)*

Or that the culture of other men may prevent them ever being able to change their behaviour as they were unchangeable, due to their intellectual limits:

If you don't understand the written word or you can't speak properly you're in real trouble in this society...that's why they've drifted into blue collar work...they're perhaps concrete thinkers... and when you're dealing in relationship problems its conceptions you try to get across. (Dr Errol Threadgold)

However, there were differences among the men and there was no one type. There were many forms of violence, many differing types of men and violence and abuse existed across cultures and classes. Specialist workers had a simple taxonomy of men they found useful:

Some men believe that violence is OK, to hit anyone, and other men believe violence is OK providing you don't hit your partner. Other men believe it's not OK to be violent. (Female domestic violence worker with men)

The following descriptions of their male patients by GPs, reflects the various types of violence and types of men. The first two represent what is described by Johnson as 'patriarchal terrorists' and fit the first level of the specialist workers' taxonomy (Johnson 1995). These men may be violent to family members and others, including GPs and their staff.

This guy was a very nasty man. He just told her if she left he'd kill her...he and a friend bashed this bible salesman really viciously and went to jail for aggravated assault. (Dr Peter Greenway)

He was the master of the house, ...a terrorising person. He used to keep a rifle under the bed...He would present as a very nice person, but you could see he had a lot of rigid beliefs about himself and his family. (Dr Harold Rosario)

Dr Jill McPherson's following patients provide a contrast between a man from a family where physical violence was the norm and another where it wasn't. These men are similar to the second and third levels of the workers' taxonomy.

Of her Koori male patient: In that family... every single one of them is a physical fighter. Unfortunately he's the strongest and therefore his behaviour is to be more judged and less acceptable.

Of her Kurdish male patient: He's quite a strong pacifist actually. We explored...his feelings and his behaviour as an answer to problems... and he had a very strong [disapproving] stance on it, because of his family's experience.

These GPs held many different views about men who abuse, but the consensus appeared to be that they are difficult to deal with. Some believed that the men could not change, others that they were able, but unwilling to, even if they disclosed their abuse. Some held stereotypical beliefs about men, including that their behaviour was the result of biology or cultural 'otherness'. This marginalising and distancing approach could originate in tensions between the doctors' masculine subjectivities and those of their male patients. Many GPs believed that men would talk about personal problems to women, but GPs of both sexes saw men and found it difficult to cope with them, as they were uninformed about men who abuse and in some cases afraid of them.

In contrast to the ways men were perceived, that is, on the whole, they can't or won't change, many women are believed to be able to change and therefore somehow responsible for not changing or leaving the situation. This is a view held by many in the wider Australian community (ANOP Research Services 1995).

4.7 Women abused by intimate partners

In the patient narratives, GPs described thirty-five women. Dr Peter Greenway was one of the best informed about symptoms indicative of female childhood or adult victimisation:

It will be tummy-aches, leg aches, headaches frequently they've been extensively investigated. Frequently has tried a variety of treatment modalities, seen three or four doctors, somebody tried them on an anti-depressant last year which didn't work....so I'll look at this pattern and I think, hmmm, somewhere in all of this we didn't get the diagnosis

right...how about I go back and ...put abuse very high on my list of suspicious symptoms and I ask...what are you anxious about?...and people are not putting, and I know I'm not sufficiently frequently putting abuse on the top of a differential diagnosis list. (Dr Peter Greenway)

Most GPs knew considerably less than Dr Greenway. Although GP pre-training survey respondents cited depression, anxiety, alcohol and drug problems as female presenting symptoms, very few mentioned vague unspecific symptoms or headaches and no-one mentioned eating or sleeping disorders or gastro-intestinal complaints. However, in doctors' stories, many of these symptoms were embedded, although they were not cited separately in the survey. For example, there were several reports of eating disorders - Dr Harold Rosario's Mrs Mizzi , Dr Sally Morris's Mrs Pickett and Dr Jane Norton's Mrs Davis (Appendix 1, Nos 5.3;3.1; 2.1). All three women attended their GPs regularly. Their doctors talked of their array of medical symptoms and in two cases, Mrs Mizzi and Mrs Davis, doctors were aware of the connections between their eating disorder and women's methods of coping with food as comfort or self-blame.

Eating is seen as an answer to the worry problem. Unless we can break that cycle, I worry therefore I eat. (Dr Harold Rosario of Mrs Mizzi)

She really blamed herself... I think my weight has a lot to do with it, because I get obsessed about my weight, I always say I'm so fat...and that gets him angry and that's why he snapped. (Dr Jane Norton about Mrs Davis)

4.7.1 Women's help-seeking behaviour

Unlike men, there are many more patterns of help-seeking behaviour which women demonstrated when attending these GPs. GPs saw women at all stages of readiness to change and with many different levels of control over their cases. Female patients attended:

- to have bruises recorded for potential court cases

The women would come along in the company of police with actual physical injuries...here are the marks of physical violence record them please doctor. (Rural female 13)

She knew what she was doing, she just wanted to come for the actual documentation of the assault. (Urban female 6)

- to have injuries treated, generally when the abuse was severe

The horribly obvious was a woman in pain...oh, she's come in about six or seven times now, each time after a major assault, bruises, kicks, a fractured elbow and that's the most obvious one. (Rural male 7)

- to present for help in crisis

I'd been her antenatal doctor...she decided to follow me from the hospital system across to this general practice and she presented in crisis, fearing for her own safety...she was sure that he would become violent enough to kill her. (Rural female 1)

- for routine health care

  She's a chronic migraine sufferer and comes along for analgesia. (Dr Peter Greenway)

  She had a respiratory infection and her partner's being driven mad by the coughing. (Urban female 7)

  We were doing a bit of a hormone interview and I asked about any difficulties with intercourse and she then divulged that she was in an abusive situation. (Rural female 1)

- for symptoms of former or current abuse

  She needed the tablets because it's her daughter's deb. this weekend and she needed to be able to cope with the stress. Her husband hasn't physically abused her for a long time in fact, but she's scared that he's still very violent. (Dr Rosalie McLeish)

  I have a woman, she had a long term problem with sleeping disorder and she's seen the Vietnamese doctor for a number of years and every time they gave her just the sleeping tablets. (Bilingual domestic violence worker)

  In my older female population I've come to recognise women who've lived and are still living in emotionally and financially, not usually physically abusive situations, into their 60s and 70s. (Rural female 13)

- with children

  [Roslyn said] - I had to tell [the other doctor] that I was hitting Jenny and I threw her across the room and she's only four years old and its not her fault and I'm sure its because my partner, he sort of shoves and pushes me. (Dr Jill McPherson)

- with her partner

  I saw a couple this morning and she's come in a few months ago very distressed. She's had a mini stroke and been admitted to hospital and her partner, they're in their 70s, he'd been bashing her when she'd only come home...we skirted around the subject and things seemed to have settled down. I don't think it's an ongoing problem but it has happened before. (Urban female 15)

- For routine antenatal care

She was pregnant and [in her] late 20s. She'd separated from the partner to whom she conceived this child because of what she thought was pretty insignificant abuse...she really described a fair bit of yelling and psychological abuse. (Dr Jill McPherson)

4.7.2 Ante and post natal abuse

Five rural doctors, the rural domestic violence worker and two urban doctors spoke of many cases where women they treated for ante or postnatal care, were abused. This is consistent with the prevalence data in Australia and overseas (Webster, Sweett et al. 1994; McFarlane, Parker et al. 1996). Several doctors were actively involved in shared care, often rural doctors did obstetrics. The recent postnatal depression (PND) project in the rural area had heightened doctors' awareness about PND in general. The abuse in pregnancy which doctors reported varied in severity. The rural domestic violence outreach worker spoke of the worst case, in which hospital workers were insufficiently vigilant about safety and access to the victim:

She was seven months pregnant, she was beaten from top to toe, I mean you've got no idea, with one of those meat [steels], that butchers sharpen their knives with...how she wasn't killed I don't know. He got in too [to the local hospital]. She was going to testify...she discharged herself and went with him.

Others appeared to be mainly psychological:

I had her in hospital because I was managing her depression and he would come and visit...he was just totally dismissive, saying she was hopeless, because she couldn't get her act together...she should be home looking after the baby and she wasn't a good mother. (Dr Rosalie McLeish)

Confirming the association with unwanted pregnancies, Dr Jane Norton described a case where a woman with a five year old and ten month old son came to see her four days after a beating which left her with bruises and swollen eyes (Gazmararian, Adams et al. 1995). She had previously seen the woman for her six-week check-up. Taking the initiative, the woman disclosed immediately that she was pregnant and that her husband had beaten her previously only during her pregnancies.

A rural female GP presented a complex case with overt and covert forms of abuse before a network meeting. A 31-year-old woman had become pregnant to her boss. He left his wife, to whom it transpired he had also been violent and moved in with her. He brought his two children at times and assaulted her in front of them. The patient was fearful about her job and finances as well as her safety. The GP felt impotent.

4.8 GP perceptions of victimised women

Similar to the interplay of perception and practice displayed with couples and male patients, the doctors had different understandings and responses as to why women did not disclose or leave and consequently how they attributed responsibility. This led to varying levels of tolerance for

women's behaviour from sympathy and understanding to frustration, victim-blaming and distrust. Some GPs, mostly female, expressed a strong empathy and understanding of why women may not wish to take up referrals or what they may have had to consider in any decision to leave.

> *It must be very difficult having gone through the anxiety of disclosing something to person one, to not feel fobbed off and having to disclose to person two and three and four and five and saying the story over and over again... I just think if I had to do that, I'd just forget it. (Rural female 11)*

Dr Rosalie McLeish compared the situation of rural women with those of women in the cities. She believed that as there were more referral services, anonymity and post-separation employment opportunities in the cities, victimised rural women were worse off:

> *I hate the word victim. I see them a lot as women that feel trapped ...because they feel trapped for financial reasons, the need for security and providing for their children even in this day and age...a lot of the women in the [rural] town have lived in the town for a long time, got married and aren't employable themselves, whereas women in the city have more employment prospects. (Dr Rosalie McLeish)*

Another rural GP had a long interaction with specialist domestic violence services and with women who had resolved their situation:

> *Hearing their stories, and hearing them speak with owning the fact that it took them a long time to come out and ...hearing about the anguish of letting the family down by presenting them with a broken marriage. The idealism of women, the preparedness of women to accept responsibility and guilt for things not going right. So I began to picture why a woman who'd been really in fear for herself and her children a few days before had in the light of day and the quietness that sort of descended, thought I have to give this another go because of all these things. (Rural female 13)*

> *Some of the victims don't feel they can get away from the relationship because of family...so they just learn to put up and shut up, but they know that I'm there...when they want to have a cry, they're quite happy to do so. (Urban female 3)*

Some GPs attributed women's behaviour to their having been exposed to domestic violence in childhood, reflecting inter-generational and social learning theories or 'learned helplessness' constructs, not always helpful as the following examples indicate. In the second example, the doctor implies blame of a woman for accepting and not having left an abusive man.

> *I've always presumed that they've probably grown up in it... without even asking the question that that's what they saw. (Dr Errol Threadgold)*

There's a few that have been hit and often it's in a longstanding relationship where that's been the pattern and someone's drunk a few cups and hits them. It's almost an expectation that that's going to happen once a week or once a month. But they don't change anything, they just stay there. (Rural male 6)

Dr Norton spoke about her struggle with a middle class moral agency and retaining her empathy in the face of frustration with women (and men) who do not feel able to change:

You tend to become a bit intolerant of people who seem to be in a position where you think they can help themselves and looking at it from your own set of beliefs and background...you can sometimes feel very impatient and you've really got to stop yourself from feeling that and go back to those beliefs that you want to hold true. (Dr Jane Norton)

Dr Jill McPherson also explained that she had to be very careful she maintained her understanding and tolerance of women who couldn't leave, when she wanted them to. She was sensitive to the impact the patient's inability to leave may have on the patient/doctor relationship.

She really should leave him, how could she possibly stay with him, she's endangering the kids, she's endangering herself, she's got to think about this and coming to realise why they might stay... You have to, otherwise every time you saw them you'd feel angry with them as if they were letting you down. (Dr Jill McPherson)

When GPs felt disappointed after women disclosed, this could reflect the personal and professional investment GPs may have in the patient/doctor relationship. An empathic male GP and educator described how, after a half-day training about violence against women, he asked his female patients about abuse. When he realised that women had not disclosed to him until he asked them directly, he expressed feelings of being 'let down':

What really surprised me was how few of the women volunteered the information but how they only responded if you asked them a specific question. And that still surprises me, even though I know the reason why. I feel like its such a revelation from my patients, its funny, you always feel as if you've let them down but they've also let you down by not confiding in you...I really feel that at this practice, we're really family orientated and they can look to me about anything, but it doesn't work like that. (Urban male GP educator)

The doctor below spoke of the need for the GP's detachment because of possible litigation between partners and how doctors needed to be sceptical of women's accounts, even in the face of injuries, implying that they shouldn't necessarily be trusted. Such wariness may reflect the publicity around some of the high profile cases involving the family court. As an initial response to women's disclosures, such an attitude may appear unsupportive to the woman.

Obviously if there's bruising and lacerations, even then you've got to be a bit wary [that they are telling the truth], particularly if solicitors are involved. (Urban male 15)

In both the urban training sessions, sessions on female victims ended with discussions about women who provoked men into abuse and who wouldn't leave, despite their doctors' strong advice to do so. The victim-blaming discussions shocked the empathic male GP educator. These discussions reflected an implicit belief that it was the women's responsibility to change the situation:

> *The guys were blaming the women or victims, but yes, it was the guys that were doing it. And I must admit, I was a little horrified by it, because I think they must be coming from their perspective...and their perspective was well, why don't they pick themselves out of that situation. (Urban male GP educator).*

Rural male 7, an experienced middle-aged male doctor who worked in both urban and rural areas, suggested a weary resignation to the difficult 'dance of detection', where a woman may drop hints, suggesting she wants the doctor to ask her about abuse (Gerbert, Abercrombie et al. 1999). He implied that (somehow) his female patients knew he could tell the difference between injuries inflicted by their partner and those that weren't and he would be giving permission for them to disclose. He did not stress his responsibility to ask, his need to be supportive and encouraging, but appeared to suggest that he and his female patient would be 'playing':

> *I'm fairly astute and I will be able to detect non-accidental injuries, so they will know, if they were coming to me, I'd be very careful, they'd obviously know that I know and it would be just a bit of a game and I'll just be giving them permission to talk (Rural male 7)*

In a case echoing Heather Osland's, he described a woman whose husband regularly threatens her life and beats her very badly. No one has yet succeeded in persuading her she is able to leave safely and he spoke of his ultimate frustration:

> *An extreme case, this woman was known to all the services and does not wish to end the relationship...but the victim talk that she was going on with was complete nonsense. It's quite obvious that her husband assaulted her, because she's in the room and its amazing that she's a person with low self esteem but she's been able to cope with intolerable circumstances. One of my greatest fears was that one day, she's going to get sick of it and she's going to kill him.*

In an extreme expression of common GP attitudes, the victim was the focus of frustration and responsibility. The doctor implied that she wished to stay and be beaten, rather than leave safely. He also indicated a fear that this wife may kill her partner, rather than that he may ultimately kill her.

Abused female patients came to these GPs for a multitude of reasons, similar to those canvassed in the literature, expressing various levels of control and powerlessness over their situation. They brought symptoms of which GPs were more and less aware, such as eating disorders, but symptoms ebbed and flowed in the longitudinal narratives. There were several instances of abuse

in pregnancy. Study doctors' levels of empathy and understanding of victims varied notably in gendered patterns and related to doctor's sense of professional efficacy and dissatisfaction and unawareness of barriers to victim's ability to leave. As male partners were less visible and more difficult to engage with, responsibility for change was often focussed on female partners.

4.9 Children and young people

Victimised women almost always had children. They often presented with their children, but many doctors were not aware of the common association of child abuse with partner abuse. Most of the time, the impact of abuse on children was not a topic raised spontaneously by doctors, but one I specifically raised with them. I was occasionally surprised at what I perceived to be dangerous situations for children, where doctors chose not to report mandated child abuse.

Dr Harold Rosario had told me of Mr. Mizzi's physical and emotional abuse of his sons (Appendix 1, No.5.3) but when I asked about child abuse, he became defensive and changed the subject. He spoke of a recent incident where the 14 year-old son had come with his epileptic mother to see Dr Rosario:

> *He's very close to his mother and I saw his eyes, there were tears and I asked him, are you depressed? What's happening at home? Oh, the usual things, his father is angry with him and beats him if he doesn't obey. He finds the slightest excuse to punish his sons physically.*

The doctor did not want to intervene and suggested that Mrs Mizzi talk to her son. Some doctors did discuss their anxieties for the children. The first doctor I interviewed told me of a woman who had attended with her sixteen year old daughter who was in year 12 at school.

> *The daughter actually feared as well that he [the father] would either severely hurt her mother, potentially killing her or backlash at the daughter for trying to help the mother. (Rural female 1)*

The mother left, but returned to her partner and the girl reported feeling unsafe again. In such cases doctors can feel uncertain about the correct balance between the mother's and children's needs. The doctor below saw a woman whose life was threatened by her male partner and who had a small baby. She was unsure whether her support for the woman would be best for the child, as the woman wasn't ready to leave. She felt very uncertain about which course of action was most beneficial and what her legal responsibilities were:

> *She didn't want to leave the relationship necessarily but she didn't want it to keep happening any more and I mean, how do you do that?...What's safe for her, what's safe for the baby, what's best for them in the long term? (Rural female 1)*

Specialist educators believed that there were many reasons why doctors didn't identify and support children. The paediatric trainer believed there were many barriers to doctors diagnosing any child abuse, from incest or sexual abuse to children witnessing violence.

> *Lack of familiarity with signs of detecting it. A psychological resistance to wanting to consider the diagnosis for all sorts of reasons, either it's too threatening, too difficult, too complex, too time consuming...will then involve too much work and be emotionally demanding. Lack of confidence in the police and child protection system.*

GPs illustrated some of these reasons the paediatric trainer identified and added others:

4.9.1 The patient/doctor relationship and child patients

Doctors in the study appeared to privilege their relationship with adult parent-patients, which together with uncertainty, could then prevent them acting on suspicions of child abuse:

> *It's a harder question to ask. Do you think anyone could be abusing this child...its just one step removed [from asking it of the person her/himself] and it's an accusing question...Are you neglecting your child, are you allowing your child to be abused in any way? (Rural female 12)*

> *You get that close to them and how difficult it is then to turn around and accuse them or suggest to them that they're damaging their child. (Dr Jane Norton)*

4.9.2 How to manage children

Many doctors expressed dilemmas about knowing what to do, if they were worried about a child. Similar to the reserve doctors felt about asking women about abuse, if you didn't know what to do, what was the point of identifying children.

> *I remember being taught how to examine their bodies, but not to be alone with children. (Rural female 13)*

> *Children who've often presented with behavioural problems and it frequently turns out to be the result of physical or verbal abuse in the home and I just don't know how to handle those children...I find its just too hit and miss. I don't know what I'm doing. (Dr Peter Greenway)*

> *His mother has raised concerns about him [a six year old boy], teachers have concerns. So how do we hear how it's actually going for him? And what things can we put into place to make sure that he's (a) safe and (b) his cries for help, which was his bed-wetting, his withdrawn behaviour and aggro behaviour at school...how are we going to approach it? (Rural female 13)*

4.9.3 The child protection 'bogey'

In some cases, doctors expressed relief at having the problem taken out of their hands by being mandated to report child abuse.

> *You didn't feel you could force the issue before but now that it's illegal, you have to, it takes away the agony of indecision for me. (Dr Sally Morris)*

However, reporting to child protection did not extend to children witnessing abuse.

> *I think the difficulty was that unless there's physical or sexual abuse, it's not mandatory to report it. (Dr Sally Morris)*

Many however do not wish to report even when abuse was mandated. Most indicated they had received no training even for dealing with reportable offences.

> *You have your suspicions about childhood abuse, but there's a lot of things you can't prove and I don't wish to, I don't think its right for me to run along and report these people when its only a suspicion of mine and no-one else's basically. And if we consider things without getting community services involved, I'm much more happy. (Rural female 5)*

Doctors spoke of their reservations about child protection services, which was a potential referral service if they identified child abuse. Ironically, a domestic violence worker also spoke about her difficulties encouraging women to take their children to the doctors, because they fear their children will be taken away. Several others spoke of their perceptions of negative outcomes of having reported child abuse.

> *A young boy's visiting his dad on an access visit and his dad whacked him and consequently I reported them. And then the dad ...couldn't see him and it just drags on and on...it just opened a can of worms and you think you do the right thing and everyone's unhappy, the mum, the dad, the stepmother, stepfather, you know, you don't make any friends out of it. (Rural male 6)*

The paediatric trainer outlined this dilemma clearly:

> *If you feel that even if this issue was reported to the police or to protective services that nothing will change and in fact there may be some overall detriment to this family, if it then means that they're not able to use local health services, not able to come back to the GP then in fact the care of the woman and her children may be decreased. So, it's a delicate balance and I think there are a lot of positive incentives for GPs not to want to diagnose domestic violence or child abuse.*

It was not difficult to understand why some GPs could overlook the needs of children, when one considered the aversion doctors expressed to the overall problem, to child protection services, their

unawareness of the links between child and partner abuse, how to manage it and the value they placed on their adult patient relationships.

4.10 Conclusions

In summary, many of the doctors spoke of their experience with intimate partner abuse overall as a difficult professional struggle, at times revealing in their discourse perceptions of profound threats to their professional and personal sense of self. They described a continuum of partner abuse among their patients from chronic and severe multiple abuses to the borders of emotional couple conflict, but many were confused about boundaries and perceived the issue very differently depending on the composition of their habitus. At times, they disclosed inconsistent views about abuse in accounts of different patients. Similar to the wider community, legal concepts of verifiable physical and sexual assault appeared to guide some respondents' awareness of domestic violence, while others, often rural, included some forms of emotional abuse. This appeared to guide the GPs' identification and perceived prevalence of abuse in their practices and their concepts of it as a problem.

Doctors described seeing female patients who had experienced partner abuse as an adult or child. Women presented to GPs for a wide variety of reasons, the majority with on-going underlying problems, but a few in crisis situations. Most were mothers. GPs described their reactions to their victimised patients from understanding, close identification and distress to frustration and anger with the women's inability to engender change. More female than male GPs sympathised with the difficulties women faced. Respondents also described a number of male patients abusing their female partners who presented with depression, pain, drug and alcohol abuses or some with mental illness. Doctors, men and men's workers also noted back problems and workers' compensation as common among men who abuse, which has not been mentioned before. The GPs' responses to their male patients were mainly uncomprehending, hostile and distancing.

Without the necessary expertise, the GPs who saw couples described management practices, which included breaking confidentiality. Some described minimising even chronic and severe abuse to focus on the medical conditions, labelling the partners' problems as marital or privileging one partner over the other, if one was perceived negatively. Part of the problem lay in the doctors' lack of knowledge about, and even fear, of men who abused, while men themselves feared disclosure and minimised their violence. Consequently some GPs' regarded women as more responsible for making changes than their abusive male partners. Respondents' attitudes and beliefs were powerful shapers of their responses to the overall problem and to their male and female patients.

With rare exception, doctors never raised the needs of children unless questioned directly. With the focus for the most part on victimised women, to a lesser extent on male partners who abused, it was almost inevitable that the needs of children were overlooked. Doctors were unaware of the

links between partner and child abuse. Many emphasised the doctor patient relationship with parents, in addition to being uncertain about how to manage child patients and holding grave reservations about the value of child protection services' intervention. All of these factors contributed to the doctors overlooking serious abuses or risks of abuse facing children and young people.

In the next chapter, I extend the implications of these data to ways in which GPs first identified those who had disclosed to them and how they then managed the problems they encountered.

CHAPTER FIVE: PANDORA IN THE CLINIC - MANAGING 'THE WHOLE CATASTROPHE'

5.1 Introduction

In this chapter, I commence with a summary of the published management principles for victimised women and for men who abuse in order to provide a context for the analysis of GP current practice in this study before training. I then examine how the interplay of attitudes, beliefs, lack of expertise and therefore confidence affects doctors' motivation to inquire directly and their subsequent pragmatic clinical judgments about management. In discussing the centrality of communication skills and counselling to effective management of partner abuse, I outline GPs' overall problems with counselling and describe how unsupported GP counselling of abuse patients impacts on levels of doctors' stress and mental well-being. I outline the many problems GPs experience with counselling partner abuse patients and raise concerns about some GPs' couple counselling practice and other couple strategies. I provide illustrated cases of differing GP approaches with female victims and male patients from what Heise would term endangerment to empowerment (Heise, Ellsberg et al. 1999). I introduce new data about GP management of men. The range of barriers preventing GP management of children is also discussed. This includes the problems of coordination when different practice colleagues see the same woman, man or different partners in a couple, which can then exclude any case management of the children. In writing this chapter, I drew from interviews with longitudinal case GP, training participants, educators and specialist workers and the published literature[5].

5.2 Published principles of GP management in partner abuse

It seems appropriate when discussing GPs' clinical work to consider the other sources of information to which doctors may have access and which could guide their clinical judgment about intimate partner abuse. As outlined previously in Chapter Two, the majority of Australian GPs have had no specific training in any family violence related strategies.

5.2.1 On women

There are several fundamental strategies outlined in the published literature. The following list synthesises the most repeated recommendations to GPs about how to identify and support victimised women. Advice such as this has been published in peer-reviewed journals and doctors magazines both in Australia and overseas (American Medical Association 1992; Knowlden and Frith 1993; Sassetti 1993; Hindmarsh 1997). Broadly, such advice tells GPs to:

- ask directly about abuse

[5] Case numbers refer to the fuller longitudinal case narratives in Appendix 1, page 226 onwards.

- emphasise the woman's safety and develop a safety plan
- believe and support her
- give information about her rights and options and if necessary, refer her to specialist domestic violence agencies,
- support her decision,
- carefully document her injuries; and
- monitor her progress.

5.2.2 On men

By contrast, the following recommendations have been published in a very few American peer-reviewed journals and it is less likely that Australian GPs would have read them. There are some brief recommendations in the updated RACGP WAV manual, which some GPs may have read (Women and Violence Project RACGP 1998). In the less widely read medical journals, clinicians involved in the re-education of men who abuse have advised doctors about their potential role with men, and how to distinguish different types of men who abuse in order to target any recommended treatment. The authors encourage GPs, when seeing a male patient who abuses, always to see his female partner separately. Doctors should warn her that her partner's decision to attend a group should not influence her decision about whether to stay in the relationship. They must check her safety and that of any children and ensure she has support and information about her rights (Hamberger, Feuerbach et al. 1990; Mintz and Cornett 1997).

Doctors are advised to:

- empathise, do not sympathise
- carefully 'funnel' (ask generally and become more specific) questions until you clarify his level of violence
- congratulate his first step and encourage the decision to change behaviour
- do not accept any excuses for choosing violence
- check his lethality and weapon ownership
- refer him to men's groups or individual counselling; and
- monitor his progress
- see his partner separately and assess her safety
- offer her support
- always ask her for feedback on her partner's reduction of violence and abuse

5.2.3 On children

So far, no literature has specifically addressed the GP's role with the children who live with abuse, other than handbooks in those Australian states which have mandated the reporting of physical and sexual child abuse (Protective Services 1993). The second edition of the RACGP WAV manual refers to child abuse, while the emphasis is on the adult survivors of child abuse. In Victoria, family violence or serious marital problems are briefly mentioned as two factors in a 'basket' of possible risk factors for child abuse or neglect in a booklet directed to medical practitioners. Witnessing partner abuse is not a reportable offence. Many rural GPs in this study said they had not received any training about reporting mandated child abuse.

5.2.4 On couples

One set of guidelines in the overseas medical journal JAMA addresses GP management when both partners are patients of the same physician. This strongly encourages doctors to monitor their personal biases, see each patient individually to assess the situation (particularly levels of safety) and assure each partner about their rights to confidentiality, autonomy, honesty and quality of care. There must be no discussion about abuse with the male partner without the woman's consent. Individual counselling is considered appropriate, only if the doctor has specialist training, but marital or joint counselling is strongly discouraged. The guidelines insist that if the doctor decides s/he will conduct such counselling, this must only take place when the violence has ended and when the doctor has specialist training in family violence and mental health issues (Ferris, Norton et al. 1997).

In summary, only clinical advice to GPs about managing victimised women has been distributed widely in Australia. No source of Australian or overseas medical advice incorporates recommendations for GP management of all family members. One Australian article on marital counselling published in the clinical family therapy literature, describes an approach (the Family Safety Model) for professional therapists who work with all members of a family when a man abuses. This approach described as 'multi-lens' is strongly influenced by the Ackermann Institute's Gender and Violence Project (Goldner 1999). It attempts to combine a feminist lens on gender and power, a systemic lens on relationship interaction, a psychoanalytic lens on individual gendering and a narrative/social construction lens to understand how culture is internalised (Shaw, Bouris et al. 1996). It is unlikely to have been read by GPs. Most GPs, if they have read anything about domestic violence at all, will have read recommended practice with female victims.

5.3 What GPs considered they should do

In a previous study (focussed only on female victims), my colleague and I found that the group of doctors we interviewed did not have a clear idea of management principles with women experiencing partner abuse and this was reflected in their reported behaviour. Few GPs mentioned: the importance of helping the woman disclose; ensuring the safety of the woman (and

her children); documentation and active management of the violence and its effects; and supporting the woman's decision (Head and Taft 1995).

In this study, I did not specifically discuss a 'role' for GPs in partner abuse in GP interviews, whereas I specifically elicited this in other stakeholders' interviews. Nevertheless, GP training participants reflected on and spoke of some victim management principles spontaneously. The education which is the focal point of this research, includes GP education about men who abuse. Participants were interested and some specifically sought training to learn about the management of men who abuse. However, prior to training the participant GPs did not have any concept of management principles for work with men or children.

Consistent with other findings, study GPs' major emphasis in speaking of management was to create a supportive environment for female victims, offering her referral options, counselling her and supporting her decision after she disclosed (Ferris 1994). This role was reactive, rather than proactive inquiring. Similarly, few referred to safety plans or careful documentation. Several referred to the lack of clarity about the GPs' role in relation to other community based support services. Similar to their role with other medical problems, GPs varied in their views about case coordination, some seeing the GPs as diagnosing the problem then handing it on to others to manage, while others saw themselves as the lynchpin to coordinate all the person's complex needs. While GPs conceived their management predominantly as supporting female victims after they have disclosed, stakeholders expressed beliefs that GPs actions could be beneficial with men who abuse and children in the family as well as female victims.

A counselling educator stated that as GPs were important '*front line services*' the quality of any process commenced there was critical to the patients' further recovery. Both women and those who support them have affirmed the importance of the first response to disclosure to later recovery (Heise, Ellsberg et al. 1999).

> *When there's been good front line work done and people are feeling hopeful, they're almost fixed before they come through the door (Counselling educator).*

There was disagreement between stakeholders about the extent of advisable GP counselling beyond crisis counselling and referral and concern about the lack of debriefing and supervision for GPs. Violence against women trainers were concerned about the extent of GP counselling skills, but distinguished a 'wider' role for rural GPs. They acknowledged the lack of referral services in rural areas. Rural community workers, they commented, referred women to GPs known to have a broad view of social health and be sympathetic and willing to spend time with victims. A mental health professional, who provided trauma and stress training, emphasised in a pragmatic fashion that because of the lack of access to mental health services in the bush, rural GPs should provide counselling for depressed and disturbed patients, otherwise these patients would receive no service at all. Men's group educators acknowledged that they had no knowledge of how GPs worked with

men who abuse, but believed that GPs were well placed to start a change process by offering men hope of change and challenging them to accept responsibility.

Thus, while specialist workers recognised the potential and importance of GPs working with all family members, the study GPs themselves were not yet confident of a role beyond responding to a woman's abuse after she disclosed it. While some specialists were concerned about the limits of GPs' capacity to counsel patients effectively and their level of support for doing so, most were pragmatic about the need for GPs to respond to needs which no other professional could meet, particularly in the country. The critical first step in GPs' management of family members experiencing violence is recognising and actively identifying that intimate partner abuse is occurring.

5.4 Opening the box – the identification process

In the previous chapter, I suggested that the GPs' feelings about partner abuse and their concepts of it affected their perceptions of family members, the prevalence in their practice and their overall motivation to deal with the issue at all. Additionally, prior to training, survey respondents showed limited knowledge of the less obvious signs of victimisation, such as frequent visits, vague symptoms and eating, sleeping and gastro-intestinal disorders (Eisenstat and Bancroft 1999). Women in my previous study suggested that both they and their children suffered all the non-specific sequelae associated with stress and lowered immune responses (Taft 1995; Head and Taft 1995). Lack of knowledge about symptoms is not limited to those of female victims, as doctors knew little about and distanced themselves from men who abused for a range of reasons. They would therefore be unlikely to actively inquire about abuse with male patients. Urban survey pre-training respondents suggested that they would learn about men's abuse first when female partners disclosed and second if men were alcohol or drug addicted.

In addition to identifying only what they perceive as domestic violence, doctors experienced the many other barriers to identification previously reviewed, such as the pressure of time, feelings of powerlessness, discomfort or embarrassment, lack of knowledge about referral agencies and personal experience of abuse (Sugg and Inui 1992). Personal experience of victimisation or perpetration is likely to be as common among GPs as in the wider community. While personal experience can be a barrier to good practice, I did not inquire about doctors' own experiences of partner abuse as a child or an adult, however the rural domestic violence worker reported one case of a current male GP's abuse of a female partner.

5.4.1 Attitudes to identification

As I demonstrated in the last chapter, doctors' attitudes can influence what partner abuse they perceived and how they constructed the problem and the players. However, beliefs and attitudes also affected how GPs then act. This finding is consistent with other studies (Cohen, De Vos et al. 1997). The data from the surveys tabulated below indicate what may affect these GPs willingness

to put partner abuse on their differential diagnosis list. The data are not generalisable, but they indicate the directions of these training participants' beliefs. A considerable majority believed that alcohol plays a greater role than it does, almost half of urban respondents that there is an obvious violent type and that child abuse is not common in families where partner abuse occurs. Rural respondents seemed more aware of the latter two issues. Of great concern is the number in the urban group who believed that it was appropriate to break confidentiality if the situation is not life-threatening.

Table 3: Survey respondents' attitudes to identification prior to training.[5]

Pre training survey	**% Urban (n=15)**	**% Rural (n=15)**
Alcohol is the cause of the overwhelming majority of domestic violence (disagree)	33	33
Men who abuse their partners are aggressive people in general (disagree)	53	73
Child abuse is very common in families with domestic violence (agree)	53	73
In non-life threatening cases of domestic violence, it is never appropriate to break the rule of confidentiality without obtaining the woman's consent. (agree)	47	Not asked

In the rural survey, GPs were also asked their beliefs about why women did not disclose, why men abused their partners and why doctors often failed to diagnose the problem. Only twelve GPs answered this section and the numbers giving the answers are in parentheses.

In response to reasons why women don't disclose, the respondents answered: they fear retribution (7); fear they won't be believed (6); and shame and embarrassment (5). Three suggested doctors' lack of time may be an influence.

The explanation for why men abuse were thought to be: alcohol (7); they learnt it in their family of origin (5) and poor self esteem (5). Four suggested that men had been abused as children.

When asked why doctors fail to diagnose, the reasons most commonly cited were: they haven't been taught (6); patients won't disclose (5) and that they find it hard to believe the male partner abuses (5). Only two suggested because GPs don't ask and four identified that GPs may not want to know about or see partner abuse.

[5] The evaluation survey questions assessed doctors reported attitudes before training. The same questions were asked in both divisions. The answers tabulated report the percentages of those respondents who answered the questions in the desired direction. Further detail can be found in Appendices 4&5.

These answers suggest that study doctors, like those in other studies, hold beliefs and attitudes hindering them asking about abuse in particular families and more generally. They understand the major barriers for women, but are more conscious of women's barriers than their own. It is noteworthy that in this rural group, five doctors spoke of their belief that doctors like them find it hard to believe that a man they know would be abusive. These and other views are consistent with the views held by GPs in overseas studies (Sugg and Inui 1992; Rodriguez, Bauer et al. 1999). When doctors considered influences on patients' willingness to disclose, they spoke consistently about the importance of building trust in the patient/doctor relationship.

5.4.1.1 Gradual disclosure- the importance of trust and confidentiality

Doctors in this study spoke of gradual disclosure being the result of trust, nurtured over time within the patient/doctor relationship. Dr. Jill McPherson spoke of the inter-connectedness of trust and confidentiality in her work. She reported a high number of both victims and perpetrators in her multicultural patient population.

> *I've been here for eight years, and they [both young men and women] used to come here with their mum when they were 10, 11, 12, 13 and now they're coming to see me a few years later down the track because they know me. And I think it makes it much easier if they know you. And they've got to have that feeling of confidentiality. So they've got to know there were other things not related to abuse that you have proven your confidentiality or stated your confidentiality on so that they can be blunt.*

The issue was the same for men who abused. If doctors reinforced trust, a man may then gradually reveal more about himself. Rick observed that over the three years he had gradually confided more and more of his previous behaviour to the male behaviour change workers, whom he now trusted.

> *From my point of view it's having enough trust or faith in someone in the medical profession that you're able to go in there and say, this is what I've done. (Rick)*

Confidentiality and trust are critical to all patients, but especially in rural and NESB communities, where interviewees confirmed that such disclosures can have a very high price in shame and punishment. The domestic violence worker reported below grew up in a home in the rural division where her mother was severely abused. As a child she had witnessed this abuse and tried unsuccessfully to encourage her mother to seek medical help, but her mother did not trust the doctors and was ashamed to be seen in public.

> *The doctors often didn't have the confidentiality either. Because they quite openly talked about what was happening with some of the women that they'd seen. ... I mean from my own personal experience with my mum. I used to beg her to go to the doctors. But she wouldn't go. (Rural domestic violence worker)*

Some doctors expressed caveats about the degree to which they were willing to maintain confidentiality, for example, when there was a risk to others or to the person themselves. Nevertheless, whether doctors were seeing women for the first time or whether they had built a relationship with female patients which engendered trust did not appear to be vital to active identification from the data. Doctors rarely asked directly, but waited for women to take the initiative. Both women and men may wait until they trust a doctor before they disclose, but doctors could ask more regularly.

5.4.2 Asking women directly

Patients want doctors to ask routinely about physical and sexual assault, but are rarely asked, whereas doctors feel they could help with domestic violence problems but frequently do not inquire (Friedman, Samet et al. 1992). Thus, not asking directly about abuse can limit doctors' ability to identify affected families. Where it was clear, in the overwhelming majority of patients, the participant doctors did not ask directly but relied on patients to disclose, whether male or female.

GPs said they identified '*when it hits me in the eye*' '*drastic cases when they've just broken down and cried or had bruises they can't hide*'.

Several doctors said that finding a way to articulate the question was difficult:

> *I didn't realise how much difficulty I had... with identifying and naming, using the words (Rural female 13)*

Prior to training Dr Harold Rosario did not believe that it was either culturally appropriate or professional to ask about private relationships:

> *I didn't think it was a subject doctors should go into and I respected the person's privacy. And I say, well, OK maybe she's a victim but she hasn't asked me. And I don't feel empowered to inquire.*

Another NESB GP added '*I'm not supposed to interrogate them about their husbands or their household because of the religious customs*'. He found men more difficult to ask, but believed that he shouldn't ask for the same reasons.

5.4 3 Asking men directly

In the focus group, men who had abused said they wanted doctors to ask directly. They described their own and other men's minimisation of violence and the need for non-judgmental, yet challenging approaches. Barry, the consumer in the men's training session said:

> *I really did want the help, but I just didn't know how to get it, I didn't know how to ask. I think if I was challenged I would have said, oh yeah, well maybe I am doing something*

wrong...As long as it would put to me in the right way, I would have just blurted it out (Barry).

Men's educators suggested that men hinted, and doctors should ask directly about partner relationships or men's anger. However, as men most often minimise their violence and control tactics, they advised doctors to be wary about accepting answers about 'stress' or 'marital problems' without inquiring further more directly and specifically.

> *Doctors will avoid it because they either don't know or don't want to know in terms of asking the hard questions about it...they're [the men] already feeling shame and guilt if they've got to a stage of acknowledging they are going to do something... [it's important] that they are then not punished, or that guilt and shame is actually heightened. You can do that further on down the track, but I think that when you're actually needing to engage them, it's about them telling their story, and asking the questions about, and then what did you do, and how many times. So if they minimise the stuff you can go after it. (Male domestic violence worker with men)*

Men's trainers emphasised the need for directness and the importance of checking suicidal ideation and men's level of isolation and lethality (eg gun ownership). In the urban survey prior to training, respondents indicated low levels of comfort in raising abuse issues with men.

Table 4: Urban survey respondents' comfort levels in working with men who abuse (percentage before training)

20% 'just comfortable'
60% 'not very comfortable'
20% 'not at all comfortable' N=15

Table 5 below shows the proportions of survey respondents reporting their identification of victimised women (although these could be longstanding patients) and men who abuse. Rural GPs were not asked about men who abuse. Hegarty has estimated that urban GPs will see up to five Australian women per week who have experienced some form of abuse in the previous twelve months. One female patient per week will be suffering severe physical, sexual and emotional abuse (Hegarty 1998). If all women disclosed (clearly unrealistic), this would amount to forty over two months or sixty over three months. If all severely abused women disclosed, it would mean eight to twelve women in those periods. Whilst all women will never wish to disclose, these figures (particularly of severely abused women) provide a comparison with GPs' reports. About half the rural GPs saw at least one woman in three months while urban doctors reported the same

number in two months. Three GPs reported seeing many more. Just under half the urban GPs reported seeing at least one man with abusive behaviour in the previous two months.

Table 5: GP respondents reported rates of identification of women and men (before training).

Urban women abused by partners in previous two months (n=15)	Urban men using violence in previous two months (n=15)	Rural women abused by partners in previous three months (n=15)
13% (0)	40% (0)	53% (1-5)
67% (1-5)	47% (1-5)	33% (6-10)
13% (6-10)	7% (6-10)	7 % (11-20)
6% (11-20)	7% (11-20)	7% (20-50)

Figures in parentheses refer to numbers identified. Percentages are rounded.

5.4.4 Identifying children

GPs appeared to have difficulty identifying explicit child abuse, while the issue of the impact of witnessing abuse on children seemed to be far from their minds. The child protection worker considered that there were three critical reasons why doctors wouldn't identify children in either category. First they have a low awareness of the impact of partner abuse on children, second they cannot actually see the impact on children, particularly if the mother does not bring them, and third they don't want to *'unleash the monster of Child Protection'*. Most doctors acknowledged the presence of children but said they did not ask about the impact of partner abuse. Yet workers with both women and men emphasised that asking about the impact on children could be a significant catalyst to both partners' desire for change in the relationship.

In summary, while direct inquiry is a critical method to more effective identification of partner abuse, most participant GPs relied on women to disclose their victimisation and their partner's abuse. As I suggested in the previous chapter, the doctors were aware that they did not identify many victims compared with the published prevalence figures. Indeed, some criticised their own efficacy because of their perceived low rates of identification. Doctors did not inquire about the impact of abuse on children, while workers emphasised that consciousness of the impact on their children is a significant incentive for change in both women and men. For some GPs, the dilemma can begin when a woman has disclosed violence, because, as Dr Jane Norton anxiously said ' *Oh, my god, what do I do now?*'

5.5 Managing Pandora and her family

Once they have disclosed, women want GPs to be supportive, knowledgeable about referrals, discuss realistic options with them and assist their choices. They want the doctor to support not only themselves, but also their children and in some cases their partners as well (Friedman, Samet et al. 1992; Taft 1995). On the other hand, GPs understandably wonder whether it is ethical to ask

directly about domestic violence if they do not then know what to do or without any evidence that patients will benefit (Brown, Lent et al. 1993; Cole 1999). Without the expertise, doctors can feel frustrated and impatient with women who don't change (Brown, Lent et al. 1993). Attitudes and beliefs in the doctor's habitus may also affect any management choices in the same manner in which they can affect their identification practice.

5.5.1 Attitudes to management practice

In Table 3 above, many of the respondents believed it was acceptable to break confidentiality if a woman's life was not at risk in order to discuss abuse with the male partner. This suggests tension for GPs between medical principles (patient confidentiality/non-maleficence), a genuine concern for the women's safety, the doctor's desire to intervene and the possibility of doing harm through a lack of awareness of the safety issues.

Table 6 below presents attitudes to management practice, where over half of the urban and one third of the rural participants indicated that they would almost always encourage a woman to leave, whatever her circumstances, in direct conflict with the principle of patient autonomy. In the second question, the majority of doctors believed that offering marital couple counselling when there is violence in the relationship was acceptable practice. These data are for very small numbers of doctors, but they are consistent with the findings of the RACGP WAV GP training project findings, where at baseline, 70% of GPs thought it best to advise women to leave (Royal Australian College of General Practitioners 1994). If these are attitudes of GPs who seek training, they may also apply to others who have not sought training.

Table 6: Survey respondents' attitudes to selected management strategies prior to training

Pre -training survey questions	**Urban (%) (n=15)**	**Rural (%) (n=15)**
The best advice to offer a woman in an domestically violent situation will almost always be to leave (disagree)	53	33
Relationship counselling works well for the majority of couples where the man is violent (disagree)	40	Na

Almost all recommended principles of management for working with both women and men who abuse rely on the doctors' communication skills. Asking sensitively and directly about partner abuse and taking a thorough history requires confidence and good counselling skills, as does clearly describing options and persuading both women and men to adopt beneficial courses of action. In this study, most doctors had not been educated to provide long term counselling and most believed their short term counselling skills needed additional training. This was clearly outlined in the rural needs assessment which preceded family violence training. Crisis counselling

of victims was prioritised as participants' greatest perceived need (Appendix 4) followed by direct questioning, enhanced communication skills and marital counselling. The belief about the efficacy of couple counselling is reflected in the number of rural doctors who sought training to improve their marital counselling skills.

5.5.2 Counselling partner abuse patients

Most GPs described their general counselling as a '*sounding board*', listening supportively or debriefing:

> *Giving them an opportunity to debrief, a lot of the time I think people just want to dump their shit so to speak and move on, and it's a nice place to dump it, it's a relatively safe environment, it's confidential and it's private. (Rural female 1)*

> *A lot of GPs that I have spoken to about counselling take it not as a structured thing, but more as listening. For [patients] to be able to talk about their problem in an empathic environment...you can say that it's a common problem and reassure them they're not going crazy... to be open-minded and neutral in a safe environment where they know its not going to get back to anyone else. You won't tell them off or that they're a failure. (Dr Jane Norton)*

Several GPs spoke of '*flying by the seat of their pants*' '*winging it*' and wanted further training to be more focussed in their counselling. Following this general description, which comes closer to active or empathic listening, there were many more detailed problems GPs discussed in their counselling practice.

5.5.2.1 Common GP counselling concerns

- **The financial and other costs of counselling.**

Consistent with research data (Britt, Bhasale et al. 1996), female GPs were more inclined than male to undertake counselling, as they were more comfortable with it, but they reported many drawbacks personally, professionally and financially:

> *I do a lot of counselling type consultations compared to some of my colleagues, who quake in their boots at the thought having to discuss any of those psychological issues and usually end up encouraging the patient to come and see me. Which consequently you then end up with an overload of that type of work you didn't necessary get into general practice to do. (Rural female 1)*

Several female doctors commented that it impacted on the diversity of their 'general' practice. They expressed some anger with colleagues who refused to take on this work and referred it all to them. Many were concerned at insufficient opportunities to debrief and some with having no supervision with more difficult cases. Dr Rosalie McLeish, a single woman, was experiencing

considerable financial burden from her levels of counselling, stress from its emotional toll and her need to increase her hours to compensate financially for her counselling caseload. This impacted on her recreational opportunities and her chances to unwind.

- **Crisis counselling, holding strategies and longer-term counselling**

Crisis counselling was the GPs' top priority. Some GPs spoke of knowing their limits with incest, sexual or physical abuse or severe depression.

> *I have counselled some people with sexual abuse and incest, but my expertise is limited and I've usually done that if I can get a psychologist in the area who can advise me and its only been with patients who you just cannot persuade to go and get expertise. (Dr Jill McPherson)*

> *I like giving them homework. I like giving them a sense of responsibility for improving life themselves. And I guess it's more effective in the shorter term. GPs can't go on with psychotherapy type stuff, it's too time consuming and drawn out. (Dr Sally Morris)*

Patients who were not ready or did not want to 'move on' troubled some GPs:

> *You can try and counsel the women who are suffering from poor self esteem and help them to become more assertive and able to make their own decisions, but you need more training for that...I think when I first did this course, I went away thinking, but what I am going to do with the women who don't want to go to a counsellor? (Urban GP project manager)*

Additionally, the doctors did not trust or (particularly in rural areas) they had poor access to referral agencies. This meant that much of their counselling would not fall in the crisis category but more of a 'holding strategy' until patients were ready to make changes and be referred.

- **The demands of thorough history taking**

Some GPs wanted to be more confident to talk in depth with an abused patient a little longer to find out more about her overall situation. They wanted to avoid superficially acknowledging such a serious issue for patients and immediately passing them onto another professional - 'fobbing off'- patients, but to learn more detail about their problems so that they could more accurately refer to helping agencies.

> *It's really easy to chop off a line of inquiry, not deliberately but just if you ask things the wrong way, people just clam up. (Female rural 11)*

- **The lack of evidence-based practice**

A few GPs would like to ask more focussed questions, as they remained concerned about vague goals, drawn out and dependent relationships, difficulties with closure, transference and a lack of clarity about good outcomes. Dr Errol Threadgold raised common questions for family doctors

involved in counselling patients with partner abuse issues. How, he asked rhetorically, could a GP assess whether the counselling intervention was effective or the GP should '*bail out*' and not waste the time involved.

> *How to finish a consultation... a lot of GPs don't know how to do that, so the simple solution is not to start...there's an issue if the patient doesn't front [turn up] because you've wasted half an hour in an otherwise busy day and you can't bill them for that. (Dr Errol Threadgold)*

- **Ethical issues**

Dr Threadgold asked about the GP's accountability if someone discloses severe abuse, was later killed and the GP had not instigated a safety plan for this eventuality. What were the GP's legal liabilities? Specialist workers also expressed concern with the lack of protocols for lethality and for the safety of women and children and the GPs themselves. This could have been the case for Dr Greenway with his patient Mr Green, if Mr Green had fulfilled his threat to '*blow everyone away*'.

- **Cross-cultural counselling**

Several urban GPs, both NESB and ESB, expressed difficulties working with women from culturally diverse backgrounds. NESB workers expressed caution at western models of counselling, which could be used uncritically with all NESB female partners:

> *There's a lot of negative associations with counselling or psychological problems that you have and [counselling] pathologises it and it's not something that women are going to [say], oh yeah, I'll go to counselling, because it is not, within the cultural context, necessarily something that has been experienced positively. (NESB worker)*

> *I think we tend as GPs to make a bit of a value judgment as to whether this person's going to respond to the type of therapies that are around... and I think you can make some glaring errors as a non ethnic sort of person [about who will and won't benefit]. (Dr Errol Threadgold)*

However, the ethnic workers advised, GPs should not make cultural assumptions, but check whether women require and are comfortable with an interpreter, with a western counselling model or whether she would be happier with a more informal form of support from other women in her community.

5.5.2.2 A profile of rural GP counselling - Dr Peter Greenway

Many GPs undertook counselling work and all experienced problems with it. Dr Peter Greenway sought training because:

I do an enormous amount of work in the area of counselling people with past history of emotional, physical and sexual abuse and I'd like to improve my skills...I'm really largely self taught in this area so I'm hoping that through this program I shall get a bit more formal tuition in an area that I already do a lot of work in.

Dr Greenway had a good understanding of the symptoms of some forms of abuse, a high index of suspicion and strove to keep abuse as a differential diagnosis. He was self-taught, ie widely read in counselling styles popular with GPs - rational emotive therapy (RET), cognitive behavioural therapy and narrative therapy, although he favoured RET. He also undertook a course in hypnotherapy in order to work with phobic patients. In order not to affect his daytime practice adversely, he had devoted an evening a week to counselling. He conducted short motivational therapy, 45 minutes long, with written homework, in four to six fortnightly sessions with a very broad range of patient problems from low to high intensity need. He spoke of excluding those who had an alcohol or drug addiction, a serious mental illness or small children. Below he describes the common methods he used with most of his patients.

I get presented with a huge range of problems, from past childhood sexual abuse through to people asking me to counsel them to present better at interviews, so they can get jobs. I find in that whole area, rational emotive therapy is powerful, quick and I would average four to six sessions with most of my people, with follow ups down the track to see how they're going...what we do at the beginning, is the patient and I decide where we want to get to, what would be inspirational for them to have achieved, and how we're going to assess when we've achieved it...So in my setting I cannot get involved in psychoanalysis, ongoing time consuming stuff, because I do have a responsibility to the community, and so I've had to be very, very goal oriented in my counselling...So in all my work...and it doesn't matter whether you're talking about domestic violence or sexual violence... I spend a lot of time with people distinguishing between what happened and the effect it's having on their life. It's the meaning that people put on things ...that disables them. (Dr Peter Greenway)

Without specific partner abuse counselling expertise, with neither support nor supervision, Dr Greenway reported experiencing problems with transference from some female patients with which he felt unable to cope, problems in working with abused children, failures with patients like Sophia and Mr Green. Some of his more unorthodox approaches resulted from his deeply felt beliefs. He spoke of considerable stress, which may have affected his own marriage.

After being up here for about 11 years, I have a head full of 11 years of fairly vivid memories...you can either be swamped by the hideousness of it all or get on with your job...There is a worry in that though, I am working harder than I was 11 years ago...It's hard to know how to de-stress yourself...on a sort of overall cumulative base - like the sort of drip, drip effect of all of this is quite hard. (Dr Peter Greenway)

Increasing demands on their counselling, little expertise or support and the range of demanding problems with which they dealt, were taking a toll on the GPs' own mental health.

5.5.3 Managing the stress of general practice and partner abuse caseloads

In the wider GP population, the range of traumatic events with which GPs deal takes a toll, with GPs having higher levels of suicide than the general population (Schattner and Coman 1998). Almost all the study GPs (26/28) reported they were suffering from stress in the two pre-training surveys, which prompted the inclusion of a session on GP vicarious trauma in the rural project and discussion of divisional strategies to support GPs experiencing stress.

> *I think the general principle in taking on working with very traumatised people is it's heavy going, it's hard work and unless you build in safeguards and precautions, there's a lot of secondary trauma. (Trauma educator)*

With partner abuse, the lack of skills, knowledge or support about how to respond to victims' needs distressed many GPs, but particularly female GPs, who empathised, if not sympathised and felt powerless to change things.

> *Sometimes myself I get depressed and frustrated, I don't know what to do...sometimes you ask yourself, did I do the right thing or not? Did I help or did I make it worse? (Female urban 9)*

> *A hell of a lot of doctors either tend to be in the category of don't want to know about it or else...they agonise over it and take any mishaps personally...earlier on when I first started treating these people I found it terribly traumatic. (Dr Sally Morris)*

> *You empathise with where the patient is and their suffering and you want them to do better. (Dr Rosalie McLeish)*

> *I think one of the hardest things is when you see someone who's really been abused...and if they're distraught, that's very hard emotionally. (Dr Jill McPherson)*

> *I'm finding it absolutely exhausting the whole process...I don't know how you cope with knowing there's a major problem and just walking straight past it. (Dr Peter Greenway)*

Wanting to deal with it, taking the time as they could not ignore it, increased the stress from other waiting patients for other GPs.

> *I think the stress is the time factor and if the person is not keen and you want to help them and you've got the house full, then the stress is for me and not the problem. (Male urban 11)*

GPs reported stress management strategies which ranged from very common ad hoc debriefing with semi-willing partners, friends and family to the very few who used therapists and structured debriefing meetings in group practices to share the burden from demanding and difficult cases.

In general therefore, counselling within these general practices was often self-taught, unstructured, unsupported and at times unfocussed. The lack of affordable, accessible alternatives for patients increased the demand for counselling care from the GPs. Partner abuse brought specific demands and added to an already demanding psychosocial caseload with which GPs were coping. Female GPs tended to have a disproportionate share of such a load and could respond to female victims' powerlessness with their own distress. I now look in more depth at what GPs narrated of their management with specific cases, commencing with couples.

5.5.4 Managing the couple

Participant GPs saw more female victims than other family members, but they did see couples. The longitudinal interviewees discussed fourteen couples with me and almost all came to the GPs' attention because the female partner disclosed. In the previous chapter, I outlined several cases where GPs' disparate perceptions of couple dynamics arose from their current habitus, as they had no more informed professional basis from which to assess the relationship and the abuse perpetrated in it differently. At times, GPs appeared to perceive partner abuse as a more serious form of marital conflict between equals. GPs' attitudes to patients also appeared to affect their management choices with couples. I have already discussed the vital importance of confidentiality in working with couples, to protect women's present and future safety and how many of these GPs believe that it is permissible to overlook this to address partner abuse. Table 6 above suggests many also believe marital counselling is effective, when there is continuing violence. I turn to discuss this as a strategy for work with couples.

5.5.4.1 Couple counselling

The male psychologist working with men who abuse, who did not think GPs should counsel couples explained his concern about 'marital counselling':

> *You can get a problem when you get a doctor who will take on a counselling role and decide that they can fix it. And particularly if a guy will present it as a relationship problem and you'll get some doctors who will engage in, for want of a better word, marital counselling...often with a lack of clarity on other referral options and whether it's appropriate. (Domestic violence worker with men)*

Couple counselling in domestic violence is controversial and (together with the care of children) an under-considered area of general practice management of partner abuse (Bograd and Mederos 1999; Ferris, Norton et al. 1999). Couple counselling strategies varied in the data presented here. Several, mostly male GPs in this sample, attempted to counsel both partners. In direct examples,

the two following quotes from male doctors illustrate the benevolent motivation, but also the lack of safety awareness, clarity or direction in some GP couple counselling:

> *A situation where for instance there was violence but there was also feelings and attachment and you know, there was a commitment to staying together then I'd sort of feel that if there was something I could do to help well that would be a good thing and I'm quite happy to have a go. (Urban male 14)*

> *I usually get them in together first off and just play round with the words and just see whether she will accuse him in front of me... but I usually don't want to accuse a man. Was he guilty of it? [The doctor spoke then of discussing the female partners injuries and depression to see if the male partner mentions his violence. His goal was trying to make them talk]...you get nowhere if you don't talk. (Urban male 4)*

The attempt outlined above was one of a number from the range of doctors who reported couple counselling, despite having no expertise in this complex and challenging work. In some instances, doctors spoke in general of being unsure how to assess levels of safety or violence effectively. Those who undertook marital counselling seemed less aware of the potentially harmful consequences. Some spoke of frequently referring to other marital counselling services if they did not attempt to counsel themselves. As there are no GP policies, guidelines or protocols in Australia to suggest this is not recommended, or to set firm principles and boundaries for when or if it is, it is unsurprising that some GP marital counselling in this study appeared not only ineffective but dangerous. The more detailed example below demonstrates how, when a man does not accept responsibility for his behaviour, couple counselling is ineffective, collusive and potentially dangerous.

Mr Starelli regularly beat and sexually abused his wife (Appendix 1, No. 5.1) Dr Harold Rosario, who had some experience in marriage guidance counselling in his native country, described the counselling attempts he made with the Starellis:

> *I went to talk it through. The system I usually say, look, whenever you talk to each other, you argue, so this time you're going to talk to me, don't talk to each other... And I ask you questions and you answer me. If you want to ask her a question, ask me and I will ask the question...to prevent them from arguing. To show them that they can discuss something without arguing. And the two of them together, they always argue. This was how I do it and usually, if there was good will they can take the ideas and try them. But in this case they were still always fighting. (Dr Harold Rosario)*

Dr Rosario perceived the Starellis in stereotypes. He was 'the aggressor', who could not control his anger and she was 'the nagger' who provoked him. Mr. Starelli believed he was justified in beating Mrs Starelli, because she nagged, an opinion with which Dr Rosario had some sympathy,

although he disapproved of it. Prior to training, Dr Rosario focussed solely on the interpersonal dynamics, and whilst expressing concern that the spiral of argument could become lethal, did not discuss protecting her safety with Mrs Starelli. After training, Dr Rosario did change his strategy. He gave Mrs Starelli a handbook about violence against women and tried to refer Mr. Starelli to male behaviour change services, although Mr. Starelli had not accepted responsibility for his behaviour but was worried about going to jail. However, Dr Rosario's discourse suggested victim-blaming and a lack of awareness of Mrs Starelli's position, particularly her financial dependency.

The Starellis were an immigrant couple, as were many of the urban patients. NESB workers highlighted some of the difficulties for immigrant couples, where women may not want male partners imprisoned in an alien country, as their partners may be their only source of support, their options are more restricted. Women may be completely financially dependent on husbands or fear their immigrant status would be at risk. Mothers may fear shame and isolation if they support their daughters to leave abusive husbands and women may fear that they will lose any rights to their children, particularly sons, if they leave. For others, (as in some Anglo-Australian couples), being a single mother may be an fearful and overwhelming prospect:

> *I saw her with bruises on her. He's real bad, and she left him several times and she's back. And I said, why? She said, the kids love him and what am I going to do with five kids? (Urban female 9)*

This suggests that those GPs working with immigrant (or refugee) patients may often be managing couples. Workers suggested that doctors have great authority in some cultures, so that their opinions may be very influential, should they condemn partner abuse and manage and refer appropriately, after informing patients of their rights.

Dr Jill McPherson's patient Mr Yusuf (Appendix 1, No. 6.1) disapproved of his own behaviour. Dr McPherson adopted a position of advocacy for Mrs Yusuf, stating her strong disapproval of violence and not accepting Mr Yusuf's explanation that he had no control over his behaviour. She challenged him to exercise control. She continued to see both partners separately and together, but when they were together, she supported Mrs Yusuf's initiative to expose the violence to scrutiny and disapproval. Dr McPherson emphasised that her knowledge of Kurdish community expectations, her networks with the Turkish women's association and her assistance with the Yusuf's workers' compensation claims were all important in her work with this couple. She counselled across all elements of what Heise outlines as an ecological model of abuse. She encompassed the social and community issues, such as Kurdish values and workers' compensation to Mrs Yusuf's abusive family background and the dynamics of the relationship.

As I outlined in the previous chapter and Mr. Yusuf illustrates, male patients who abuse hold differing attitudes to abuse and these affect the potential for beneficial intervention to stop violent

behaviour. A few men may feel guilt and accept responsibility and may not feel ready to be referred.

The examples above suggest GP couple counselling of partner abuse is problematic. The GPs in this study responded in a range of pragmatic and instinctive ways. More male than female GPs counselled couples, irrespective of the male partners' attitudes and their relationships with him. One female GP in a well-resourced public health centre was able to achieve some progress with a multiplicity of strategies. Couple or marital counselling is not always considered in medical advice about domestic violence, but often contra-indicated when it is (Herbert 1983; Ferris, Norton et al. 1997; Hindmarsh 1997). Whilst there is considerable disagreement among them, some specialist therapists will counsel couples, but only when a male partner accepts responsibility for his violence and both partners wish to maintain and improve the relationship (Goldner 1999). The specialist domestic violence workers in this study did not believe GPs had sufficient expertise to distinguish which couples could safely be counselled or that they could do so effectively. Many GPs preferred separate management strategies.

5.5.4.2 Other couple strategies

Rural male 7 managed many couples where partner abuse occurred. He indicated he often '*picks up the pieces*'. He discussed his discomfort with managing couples:

> *The woman might come along saying look, I've got a problem with my husband... he's depressed, he's getting violent and could you speak to the husband about it...it felt uncomfortable with both partners seeing the one doctor...you're acting as a mediator, not as the patient's GP. (Rural male 7)*

He therefore referred his patient, Mrs Davis to Dr Norton, his practice colleague, but did not have a process for coordinating the Davis' care. When another of his female patients expressed concern about her severely depressed partner and disclosed violence, he asked if it had happened before. The patient told him she was deaf in one ear as a result of assaults. His reflection emphasised her gender role:

> *This was all news to me...when his frustration blows, he just blasts away...his health has deteriorated and she's more in the caring role for him now.*

Despite an apparent pattern in patient couples he described, Rural male 7 did not report inquiring systematically or managing partner abuse when a man was mentally ill or coordinating care with colleagues, but appeared to prioritise the illness and female partner's caring responsibilities, while minimising victimisation.

Lack of confidence about how to manage impedes GPs work with couples. In a distinctly under-confident manner, an urban female GP reported her inability to ask whether an abusive older man had continued to bash his female partner about the head after she had a stroke as she recently

disclosed. When they attended together the following time, she did not ask to see the older woman separately:

> *I didn't actually sort of confront or ask him...I suppose she would have told me if it had been a problem. (Urban female 15)*

There were several examples in Dr Threadgold's patient narratives (Appendix 2, No.2) where he saw both members of a couple. In these instances, without expertise and with time pressures, his major strategy appeared to be medication of the female or both partners. In Jack and Andrea's case (Appendix 1 No. 7.1), Dr Threadgold was not confident about what to do and his management did not extend beyond medicating and chastising Andrea, asking her to attend couple counselling and suggesting time out to Jack. Similar to the case of Fatima (Appendix 1 No 7.2) and her partner (whom he saw only infrequently), any progress was achieved by the woman herself. With another violent male patient (Appendix 2 No 2.3), known to several doctors at his clinic, in which children were also at risk but the NESB female partner felt unable to leave, Dr Threadgold read from the files that the man was *'lazy, violent, poor judgment with children'*. However, doctors were unable to extend management beyond medicating both partners. There was no protocol in the clinic for coordination between practice partners to check whether the frequency of violence and level of safety for the woman and her children had changed, as recommended in overseas journals (Flitcraft 1995).

In several other cases, GPs manage health problems and encourage the man's control of health damaging practices such as alcoholism or smoking, but the abuse remains unchallenged. In several cases where women were unable to leave, but the man had a chronic condition of some kind, eg manic depression or liver failure, doctors focussed attention on the man's medical condition and the woman's caring role. It seems clear doctors are unaware what to do, however such actions may seem implicitly collusive as the man's abusive behaviour and the woman's victimisation appear to be less important than his medical conditions.

These further examples suggest that without professional expertise, support or written guidance, these doctors found it difficult to respond other than bio-medically to either partner or reinforcing the victimised women's caring role, rather than attempting to deal with the abuse. This can implicitly reinforce her victimisation and contribute to her feeling of helplessness. These doctors did not refer to specialist community based agencies, which could offer more effective help. While GPs may see both partners, more GPs saw only the female partner and focussed attention on her. However, without understanding what may be preventing her making changes, not all this attention is beneficial.

5.5.5 Managing women

> *It's really important that you're very careful that you're not acting as if you accept and condone the fact that there's domestic violence. Oh yes, everyone experiences it, you're just*

one of them, so let's have a talk about it. You've still got to get across the fact that no, you shouldn't have to be subjected to this. (Dr Jill McPherson)

Some participant doctors offered good examples of supporting victimised women, condemning the abuse, moving beyond a conservative medical model, counselling intuitively well and seeking to empower their patients toward beneficial change. Others believed that their best strategy was to advise women to leave. This was consistent with the wider Australian community's belief that women in abusive situations should leave (ANOP Research Services 1995). The desire to encourage a woman to leave was evident in several doctors' accounts of their management, and in the previous chapter I argued that when women remained or returned to abusive partners, doctors could respond with frustration, condemnation, impatience or worry and hopelessness.

GPs appeared to try many different strategies with the same women at different times, including encouraging women to leave, but often incorporating strategies from undergraduate training rotations and their own life experience, later adding what they have learnt from the training projects. Those doctors who undertook drug and alcohol or psychiatric rotations often mentioned these as useful to their practice, which was not surprising, as both female and male patients experiencing abuse could suffer from these inter-related problems. The following examples of GP management of women illustrate differing balances between women's agency and GP control of the patient/doctor relationship and the varying levels of support offered to women to make decisions about their lives. In the context of intimate partner abuse, empowerment strategies may mean informing and supporting women to make changes in their lives and attempting to improve damaged self-esteem. Both Dr Rosalie McLeish and Dr Sally Morris spoke of counselling women who were very depressed and had poor self-esteem. Both doctors used a variety of self-taught strategies.

5.5.5.1 Raising self-esteem - Alma Matthews and Mrs King

Alma Matthews (Appendix 1, No.4.2) was a woman in her seventies who did not have the strength to leave a sexually abusive husband, but who came to see Dr McLeish to unburden what had been happening to her, allowing Dr McLeish to affirm her worth and that it was not her fault:

I don't know that I particularly changed her life, but I've made her life more bearable... because she can come and tell me things that he does, it enables her to exist, because she can off load it onto me... she's not going to leave the marriage. And that's O.K....We've talked about it, she just doesn't feel she can do it. She's... never been on her own in sixty years...But she can be on her own within the marriage... [she knows] that I still thought she was an O.K. person, that all this stuff was going on around her... it wasn't tainting her. (Dr Rosalie McLeish)

Mrs King (Appendix 1, No.3.2) was a victim/survivor of her father's physical abuse of her mother and herself. She saw Dr Sally Morris for her phobias and low self-esteem. Dr Morris' counselling

included helping her to overcome her fears of public speaking, and asking her to list ways in which she had achieved successes with her committee work and her children. Mrs King's self esteem grew and she became chairperson of her committee.

5.5.5.2 Patients control the agenda - Mrs Evans

Dr Jane Norton's patient Mrs Evans (Appendix 1, No. 2.3), had a clear agenda. She attended in order to arrange a pregnancy termination and a referral for her male partner who had agreed to do something about his behaviour (she probably threatened to leave him). He had physically beaten her when she admitted she could be pregnant. He had done this twice before when she was pregnant and this time he hit her in front of their two young sons. He agreed his behaviour was wrong. The patients doctors find easiest are women such as Mrs Evans, who have obvious symptoms such as bruising, disclose easily, whose partner wants to change his behaviour and who are clear about their needs.

5.5.5.3 The control paradox - Mrs Pickett

Both Malterud (Malterud 1993) and Candib (Candib 1994) emphasise the importance of relinquishing control and empowering female patients, particularly greatly disempowered patients, such as abused women. However, the process may not be straightforward and when women make choices about control over their own bodies, it can generate dilemmas for the GP.

Dr Sally Morris' patient Mrs Pickett (Appendix 1, No.3.1) had been married for twenty years to a very abusive husband and her sixteen-year old son was also exhibiting some hostility to her. She had previously had a nervous breakdown and attended a group for tranquilliser abuse. Her husband wooed her when she was in hospital and resumed his abuse when she was released and threw away her medications. Dr Morris thought Mrs Pickett had insufficient support networks:

> *He [her husband] had never been willing to seek treatment himself, and she talked about how she didn't feel she had the confidence [to leave], and she was nervous about the fact that she didn't think she would get her share of the value of the house etc. I remember talking to her about where she could get legal advice from, and we talked about an awful lot of things, and I actually spoke to her about self confidence...and also assertiveness, because she was kind of treated very badly at her work at that time too.*

Four or five months prior to our final interview, Dr Morris said Mrs Pickett had left her badly paid job and evicted her husband, although he was still harassing her, but to Dr Morris's frustration she hadn't followed up with counselling. She reported an improved relationship with her son and had established a support group herself, from which she gained self-esteem. She had prioritised these above controlling her abuse of medication or managing her high blood pressure and bowel problems more effectively. Dr Morris had commented on her low weight and was concerned about either anorexia or bulimia. Since then, Mrs Pickett's chemist had rung expressing concern about the number of laxatives she was purchasing. In her own hierarchy of needs, freeing herself

of her husband's control allowed her to take control of her own body, albeit possibly harmfully. She therefore kept her doctor's control at bay, by not attending for follow-up appointments and not having tests. Dr Morris' support and advice appear to have assisted Mrs Pickett, but left Dr Morris concerned that she hadn't fully treated her. This illustrates the paradox of empowering patients to take action, after which they may wish to exercise control over the patient/doctor relationship to the frustration of the doctor.

5.5.5.4 Encouraging women to leave - Mrs Mizzi and Janet

Almost all these doctors offered the woman the option to leave if she expressed distress at what she was experiencing. Heise's model comparing entrapment and empowering management strategies highlights the fact that how and when a doctor suggests this is critical. There are two contrasting examples in the data presented below. These management models and the ecological model of abuse recognises that an abused woman lives in a wider context which impacts on her options (Harvey 1996; Heise, Ellsberg et al. 1999).

Dr Harold Rosario reported encouraging several women in seriously abusive relationships to leave, including Mrs Starelli and Mrs Mizzi (Appendix 1, Nos 5.1; 5.3)

> *She [Mrs Starelli] came to me and I said why? Look can you give me a reason, a good reason, why you're still living with him, apart from fighting all the time? And she said, no.*

He constantly advised Mrs Starelli to leave, but she didn't want to leave before they sold the house *'because she will have nothing'*. When I asked if Mrs Starelli was worried about money, Dr Rosario told me that most of the arguments in every home were about money. He appeared to be unaware of her need for financial security, independent housing or her low self-esteem or confidence to act independently.

In some cases, it may not be within an individual clinician's power to help, even if s/he tries, because the wider system may be ineffective. In the following case, Dr Peter Greenway attempted to provide a young severely abused woman, Janet with all the help he was able. He had known Janet's family for ten years before she first came to him four years earlier with skull fractures and sub-dural haemorrhaging she and her partner attributed to a car accident. Since that time, as she came and went in crisis, he learnt that her partner was a generally violent criminal and that she was regularly beaten up. Over the intervening years, both Dr Greenway and his wife attempted to persuade Janet to leave with her by now two small children. Dr Greenway treated Janet's parents for anxiety. He recognised it was *'way out of my league'*, and when she presented recently, he had rung the police, his Melbourne lawyer to arrange an Intervention Order immediately and tried to seek refuge for her. The male partner responded that it was *'just an effing piece of paper'*. She returned to her parents for a while, but with both the partner and his family threatening to kill her if she left, she vanished. Dr Greenway informed his patient of her rights and may have helped her to escape, but while she is out of contact, he remains concerned for her safety.

Similar to Dr Rosario, other GPs were not conscious of the broader needs, eg financial support, alternative housing, custody issues and legal advice, which must be addressed for women to be able to separate successfully. Wider structural issues are difficult for doctors to manage if they are not networked into the wider family violence system. Neither were some aware of the stages which some women experience, the so-called 'cycle of violence' which may mean that encouragement to leave at the wrong stage, eg a wooing phase, will most often fail, irrespective of the support offered. If a doctor advises an abused woman to leave before she feels ready and has sufficient means to do so, he may put her at risk, as women are most at risk of murder just after they separate (Campbell 1992).

5.5.5.5 Knowing what's best - family reconciliation and counselling - Amanda and Sophia

In the previous chapter I described the cultural strands informing Dr Peter Greenway's practice. The following examples illustrate how this affects his management of some female patients. Dr Greenway's patient Amanda (Appendix 1, No 1.1) illustrates the paradox of terminology and the complexity of practice in this area. He presented Amanda and her family as one in which there:

> *Was a fair bit of domestic violence going on between mum and dad, and mum was alcoholic and there was a lot of fighting going on. Not just dad against mum, in fact mum used to get very drunk and hit people and thrash around.*

Therefore in partner abuse terms, she was an abuser. In fact, Dr Greenway's high index of suspicion led him to ask her about her childhood when her undiagnosed chronic aches and pains and sexual dysfunction had no other obvious aetiology. Over several sessions, she gradually disclosed a childhood from 10-14 years old of severe paternal rape. She was therefore both 'victim' and 'perpetrator'.

Dr Greenway was critical of the available psychologists and psychiatrists to whom he might refer. He was even more critical of the local sexual assault services, which he (and in some cases Dr Morris also believed) maintained women in victim mode. His stated counselling goal was to alter the disabling meanings (Amanda's 'hideous gargoyle') patients attach to traumatic events. In Amanda's case he wanted her to forgive her father for chronically raping both her and her sister:

> *The reason I want them to forgive the perpetrator was part of me being in the country. I'm part of this community, right? And I have my successes and I have my failures, right?...So I very much take the view that we have to create a relationship which was actually going to function. And my personal view, having spoken to several people who've been through CASA [sexual assault service], was that they actually don't function particularly well, they still don't have a way of handling that relationship.*

She was a family friend and part of Dr Greenway's church social network. He spoke of the importance of using such informal networks to support victims' recovery. Dr Greenway said

Amanda's symptoms had vanished, her drug and alcohol addiction was cured and the couple violence also ceased.

In a further example, after direct questioning following no obvious diagnosis, 17-year old Sophia (Appendix1, No 1.2) disclosed some sexual abuse by her grandfather and her father's friend. While her mother believed her, her father threatened her with assault if she repeated the allegations. Her mother had taken out an intervention order against the father, alleging abuse. Dr Greenway's counselling goals, to reconcile Sophia and her father, appeared again to prioritise family reconciliation and forgiveness. He had to obtain special permission to breach the order to bring them together. While initially successful as her father said he did believe her, Sophia later returned to her mother and refused to see her father.

Whilst Sophia's reconciliation failed, Amanda appears to have improved over the last 18 months, although it is possible residual issues may appear later. In the absence of any professional guidance, Dr Greenway's self-taught counselling methods privileges family reconciliation and forgiveness over tackling the abuse. These methods would be controversial and challenging to many feminist practitioners and to some in the legal system.

5.5.5.6 Case management in partner abuse - Mrs Davis

In group practice, doctors can see both partners in the couple or different doctors can see either partner in a couple. Flitcraft cautions medical practitioners to be alert to any changes in a victim's injury patterns, the frequency of abuse and the levels of fear in victimised women (Flitcraft 1995). This is difficult to achieve if GPs in a group practice have no formal process for coordinating care of abused patients.

The lack of coordination between doctors in a group practice constrained what Dr Jane Norton was able to achieve with her patient Mrs Davis (Appendix 1, No 2.1). Mr Davis was the mentally ill patient of Dr Nortons's older, more experienced colleague (Rural male 7), who previously saw both partners. He monitored Mr Davis medication and his manic-depression. Mr Davis exploited his wife financially and emotionally, and assaulted her in cycles associated with taking himself off medication. Mrs Davis went to consult Dr Norton about her weight to which she attributed her husband's violence. The two children, ten and seven, witnessed the abuse and in the event which Mrs Davis disclosed, her son was abused too. When Mrs Davis first disclosed, Dr Norton was overcome by panic and feelings of uselessness. She continued to see Mrs Davis over the following year, listening supportively and treating her symptoms (eg referring her to a dietician for her weight). At our last interview, Dr Norton voiced her concern about potential abuse:

> *She actually had an appointment with me yesterday but didn't turn up, so I don't know what happened there. But umm, her, but her husband has actually taken himself off the medication again, so she was worried that things may escalate.*

As there was no structure or protocol for liaison with colleagues in such cases, Dr Norton's ability to coordinate care for Mrs Davis and her children was impeded. As a junior colleague, she felt she could not discuss preventive action or behaviour change for Mr Davis with her more senior colleague or the impact and implications of violence on Mrs Davis or their children. She supported Mrs Davis' coping skills and caring, but was not able to empower her to change her situation nor to debrief her own feelings with other than her parents and partner.

5.5.5.7 Coordination and neglect -Fatima

In the following case, several doctors saw the female patient and her daughter, but did not coordinate with other colleagues to maintain vigilance about their safety or ongoing suffering. Fatima (Appendix 1, No 7.2) first attended Dr Threadgold's surgery for an unwanted pregnancy and termination in 1991. In 1993, she disclosed to another doctor that she had been beaten and the doctor recorded bruises to her upper arm. She attended regularly as she suffered from chronic eczema and allergies and her young daughter with asthma, later nightmares and other behavioural symptoms of abuse. Reviewing her notes, Dr Threadgold explained how Fatima had carried this burden for six years:

> *There were odd sort of...sexual things to do with the contraceptive pill and discharges and bits and pieces, but nothing really particular or specific. Then through 1993, sort of chest pains and rather non-specific musculo-skeletal type things... and then the admission that the arm had come from a beating from her husband... And then we get into 1995. So really, she tended to put up with that for a long period of time, but she was really the one who did everything. We were just ...an occasional complaint house, rather than actually managing anything, she did it all herself.*

In 1995, she disclosed repeated beatings and a dictatorial marriage. Dr Threadgold spoke of his surprise to hear this of her husband, but said he believed her. She was desperate, but just wanted to 'talk about it'. Dr Threadgold was unsure what advice he gave at the time. The couple attempted to improve the relationship by moving interstate but this did not work, so on her return Fatima separated from her husband. Dr Threadgold then supported her Crimes Compensation court case with letters about her abuse symptoms. Following her separation, Fatima's allergies improved dramatically. Whilst the repeated presentations, clear symptoms and disclosures are outlined in the files, the clinic doctors appear not to have consulted with one another or dealt with Fatima's suffering or her and her daughter's safety at all. The lack of practice case management also emerged for Jack and Andrea and other patients in Dr Threadgold's practice. As did others, their clinic reserved lunches for drug company presentations, apart from 'corridor chats', Dr Threadgold recognised that the number of case coordination meetings may not be adequate for the scale of their patient population:

I suppose we've had these discussions about problem patients maybe six a year, you know, its not very many considering we're seeing 4,500 a month.

5.5.5.8 The despair of revolving door abuse victims

Several doctors spoke of women who presented many times, badly beaten up, but who returned to their partners. Such women may have seen many community agencies, but still return to have injuries treated and or documented in their struggle to free themselves. Several doctors expressed a desire to free these women and solve their problems. They expressed despair and anger when they could not manage this. They had neither the expertise nor knowledge of sufficient referral agencies with whom to coordinate and refer.

In summary, without structural, educational or professional support, the doctors described a spectrum of management responses with female patients from escalation and entrapment to empowerment. Within their practices, the doctors offered individual eclectic and contingent responses to individual victims and couples. Female and male GPs appeared to practise differently with female GPs more vulnerable to distress about the lack of an ultimate solution and some male GPs unconsciously privileging traditional female roles of caring and family reconciliation, while minimising victimisation. Doctors in the study demonstrated how lack of coordination and understanding about victim's needs constrains effective care for female patients. Others illustrated practice in all levels of Heise's ecological model. Both similar and different patterns emerged in doctors' reports of their work with male patients.

5.5.6 Managing men who abuse

As I outlined above, the doctors in the study expressed considerable discomfort about working with male abusers and some stereotyping about what kinds of men might abuse. I have described some strategies for managing male partners in the section discussing couples. In those examples, Dr Rosario and Dr Threadgold expressed sympathy for the male partners' difficulties with their wives. In both cases the doctors suggested marital counselling. In another case, Dr Threadgold focussed on the man's medical condition and not his abuse. Dr Greenway treated Mr. Green's injuries, attempted counselling and only became aware of the violence when it became lethal, despite a high index of suspicion of abuse in female incest survivors. These strategies implicitly colluded with the abuser and could undermine his female partner, as the doctor may be perceived by her to support him. This could explain some women's beliefs that male GPs 'side' with their male partner (Taft 1995: Head and Taft 1995).

Ex-abuser participants and workers with men also spoke of GP responses including the medicalisation of depression and stress, inappropriate GP marital counselling when men presented the issue as a relationship problem, or GPs' inability to challenge men's minimisation and denial. As a worker described Barry's visits to his GP:

He went there to get a script. But it was anti-depressants, it was things often pointing to, there's more than goes on here and they missed it. And Barry was able to say, look I really, I just wanted them to ask. I wanted to tell somebody about this. I hated my life. I hated who I was. I hated how I was behaving...I didn't know who to talk to and if only they had asked the question it would have been a relief to answer it. (Male domestic violence worker)

The doctors reported a notable number of male patients attending for workers compensation or back injury who were later found to be abusing their partners. Most GPs only managed the men's medical symptoms. Dr McPherson emphasised that she had a systematic approach to workers' compensation cases, which assisted her in identifying partner abuse:

I always insisted with my workers' compensation patients that we explore the emotional issues, the home issues, all of those aspects. I don't think you ever treat anyone just for the particular workers' compensation injury. You've got to always assume that it's going to have a great impact on other areas of their life. (Dr Jill McPherson).

As well as seeing separated victimised female patients, GPs saw male patients with widely differing levels of need who were separated as a result of their violence. Two young men in their early twenties came to see Dr Norton (Appendix 2, No 4.22&4.24). The first man, sent by his girlfriend who was also Dr Norton's patient, presented with hand injuries and soon disclosed alcohol addiction and anger problems. After training, she congratulated him on his bravery in disclosing and referred him to a male counsellor at the CHC. She attempted to deal with his medical problems, but he did not return. The second, whose girlfriend had left him and taken their child, already had other counsellors, so that Dr Norton offered backup non-judgmental support and anti-depressant medication.

Dr Norton also treated Mr. Connor, a separated man who had abused his partner, and who had high level complex, inter-related needs. He was an incest survivor with psychiatric problems, including suicidal ideation, custody of his fourteen-year old son and who was very cynical about 'the system'. He had already referred himself to anger management at the CHC. Mr. Connor was desperately poor and couldn't access his superannuation. Dr Norton had seen him a few times, after which despite a court order prohibiting alcohol:

He'd cut himself quite badly with a knife and was cut on his forearm, cut all his legs, through his jeans and was bleeding and had sort of these superficial but gaping wounds everywhere and was quite drunk. (Dr Jane Norton)

Mr. Connor was in crisis. Dr Norton drew on her earlier education in dealing with angry patients and her drug and alcohol training to sustain Mr. Connor through this period. She saw him frequently, concerned that the only thing preventing him from suicide was his son. She struggled over her management of him:

He's talked about killing himself... I tried to make a contract with him one day, when I was a bit worried he would suicide, and he said, oh look, I've done this hundreds of times. And there was no way he wanted to write anything down. He said it doesn't mean anything anyway, it's to save your neck, and you know it...He feels that the whole worlds against him and how can a pill help, and you're just trying to drug me up.

She was stressed by the incident and was only able to debrief with her parents. Later, shifting her focus out into the system, she was able to advocate for his rights with the superannuation company, resulting in his access to some funds. In this way, she built trust and he won his court case. Having assisted him to gain money and not resort to suicide, Dr Norton believed she had achieved some success, despite not being able to persuade him to treat his alcoholism or to assess his 14 year old son's unsupported but obvious needs.

Dr Norton drew on her previous training and natural empathy to help Mr. Connor. Her group practice, current domestic violence training and the wider system (the superannuation industry and psychiatric services) were inadequate support for a young female doctor with serious cases such as these and it left her vulnerable to burnout. She subsequently left the practice.

Dr Jill McPherson learnt from her experience with the Maltese couple to guard confidentiality in abuse cases. Like Dr Norton, her advocacy around material support enabled her to gain Mr. Yusuf's trust. Together with her support for Mrs Yusuf and knowledge of his community, she then taught him that he could exercise control over his abusive behaviour. She maintained the same value position with Bill (Appendix 1 No 6.3), that his violence was not acceptable. He was not yet committed to change his behaviour, although he has accepted his behaviour was wrong.

In summary, doctors identified and treated men who abused, practising eclectically with varying levels of success. Male doctors appeared to be more at risk of collusion, while female doctors, such as Dr Norton empathised with young men without being able to challenge their behaviour and without adequate debriefing, at some cost to herself.

5.6 The invisibility of children?

I had one, just recently, how old was she?... Seven. And this mother was saying very clearly, it's not affecting the kid. And yet she was a bed wetter, and she had lots of the classic symptoms, gorgeous little thing. And I said to her, Katie, how come you're wetting the bed, what do you think that's about... And she said that's because I get scared. And I said what do you mean, you get scared? And she said, well, I hate it when mummy and daddy fight. And then I said what do you do? And she started telling me, I hide in the cupboard, and I take Jack with me. She had this whole behaviour, a way of protecting herself and her brother, who was about two, of getting into cupboards... And I said if you ever got really, really scared, where would you go, what would you do? She knew she might ring up her nanna. I mean, we're talking a seven-year old girl. And I ended up having to put a

notification through to the Department on that one. Because she also told me about a time when she thought Daddy was going to suffocate her. He got really angry when she wet the bed and held the pillow over her face. (Female domestic violence worker)

Symptoms and strategies of those like the little girl above are common in children who live with chronic violence. Children vary in their response to partner abuse. However there is evidence that significant damage can be inflicted early and if left unchecked can develop into further psychological damage (James 1994). Many women will bring small children to their doctor, but very rarely will the doctor either have or make an opportunity to speak to the children directly. Most do not ask parents about the impact on children or, similar to adult partner abuse, will only inquire when there are physical injuries. Others will treat symptoms, even behavioural ones, which can be misdiagnosed as eg Attention Deficit Disorder (ADD).

I think many of the kids actually present to GPs with those symptoms. And they're referred on to specialists, with ADD, all those sorts of things. And again, many of these kids have actually come from very abusive, violent backgrounds. (Male domestic violence worker with men)

Only Dr Rosalie McLeish spoke of her awareness about the danger of abused women abusing their children:

I actually always ask any patient, apart from asking them are there any self harm issues, I always ask them are you concerned you may harm your children? I always ask them. (Dr Rosalie McLeish)

No doctors mentioned asking men such questions, which might allow them to disclose their fears of abusing their children or of understanding that they might wish to disclose. In behaviour change groups and counselling, providers said that asking men whether they wish their children to grow up like them was a catalyst for change, but the GPs were unaware of this.

I have already discussed some of the barriers GPs may feel about identifying children: not understanding the impact on children; not perceiving it; not wishing to jeopardise the relationship with parents. While several GPs spoke about their discomfort accusing parents, the following doctor was direct about the problem:

In most cases the parents will explain that [bruises, injuries] in a reasonable fashion, or certainly not admit to any self-injury that they've been involved in, or any contributing cause for themselves. And I suppose as our patients, we have to accept it to some extent. I mean if we don't, they're only going to go to another doctor. We're in the situation of having to maintain our patient loads for our income. (Rural male 8)

Many doctors do not understand how to ask and if the abuse was reportable, were not confident that taking action would produce a beneficial outcome:

You ring some alarm bells and people come round and say, we're going to remove your kids from your care, or that sort of consequence was a fairly dramatic thing and it's a bit hard to know in an individual family whether that's going to be a long term benefit or not. Bearing in mind that a lot of people are able to still continue to cope with that and stay together as a kind of a unit. Even with violence going on. (Rural male 6).

Sustaining the family unit, despite domestic or family violence is a further consideration voiced in this GP's reservations about reporting child abuse. Such a view can often be held by women themselves and if both GP and victim hold the view, it is less likely that either child abuse or domestic violence will be dealt with. A few doctors spoke of the difficulties of disentangling real child abuse from the accusations when parents are separating and mutually accuse each other of abusing the children. They may ask the doctor to become involved and several expressed discomfort with this.

Dr Harold Rosario told me of having observed the depression of the teenage Mizzi boys and asking the youngest about his tears (Appendix 1, No 5.3). The boy told him of his father's beatings. Dr Rosario did not consider reporting to child protection services, but asked his mother to comfort him. In Dr Rosario's community, such beatings may be acceptable. The child protection educator considered that Anglo-Australian workers might confuse child abuse with what is acceptable punishment in other cultures and that this was problematic.

Abuse occurs on a continuum, and within every culture there's appropriate discipline to the culture and inappropriate discipline to the culture. (Protective services educator).

GPs might not have been confident that they understood the limits in culturally diverse communities. This might result in inappropriate actions, either not reporting due to misplaced caution or reporting due to misinterpreting a culturally different adult's actions. While GPs can inquire about culturally acceptable limits in their patient population, they ought not accept culture as an excuse for serious breaches of Australian child abuse law.

Doctors did not speak about referring children for the explicit impact of abuse. Dr Peter Greenway and Dr Errol Threadgold referred children on to paediatricians for symptoms associated with witnessing partner abuse, rather than support to overcome the effects of it. Dr Jane Norton, despite her empathic care of Mrs Davis and Mrs Davis' concern for the impact on her children, did not refer the children for assessment or support.

Workers with children spoke of the need to ensure the child had another adult with whom to debrief and to whom they could turn if they felt unsafe. Dr Jill McPherson checked this with Jenny, Roslyn and Bills daughter, after talking to her about the impact of her mother's abuse and her father's violence. More in-depth support was being provided by child protection services, but Dr McPherson was not sure how much. She spoke with frustration, as many doctors did, about the lack of coordination and feedback from the child protection service system.

Some doctors dealt directly with teenagers who lived with violence. When young people wished to attend the GP themselves and speak about their problems in confidence, structural barriers could make this problematic, according to domestic violence workers:

> *[Young people say] my mum and dad go to that surgery and they know that receptionist, so I don't want to go there. And when I've rung other surgeries, then they've rung me back and said, I can't see this child, without a Medicare card...[Worker 2] And also they don't bulk bill a lot of them. So if they don't bulk bill then part of the bill will go to the parents. (Domestic violence workers)*

Young people may be victims in their family, alternatively doctors may see teenage boys who are using violence against parents. A few doctors mentioned:

> *The grown up child, even 15 or 16, and the mother may be weak and helpless, or psychologically or emotionally not able to stand and the child threatens to kill them, give me the money I want to go, I want to gamble, I want to buy the drugs, and she has to give him the money. (Dr Harold Rosario)*

Most doctors recognised a need for more expertise in working with children living with violence and when asked to reflect on the needs of children agreed that their needs were overlooked.

5.6.1 Who advocates for the child?

If a family saw their doctor, or each parent saw different members in a group practice, the needs of children can be easily overlooked. One rural female GP had been discussing this problem with workers in the family violence network, where they were very concerned about confidentiality and coordination for the child's benefit:

> *If two GPs, if one will see the mother, say and the other will see the father or male partner. What rights, what are the duties of confidentiality and what about corridor conversations?.. There's a need to work together and make sure that each person's interests in the scenario are being met and in particular the child... who's looking after whose interests, particularly in a multi-GP clinic like this?...the GPs are thinking, well I hope that Protective Services are continuing to monitor the situation, but what's my role in this? (Rural female 13)*

Dr Errol Threadgold expressed further concerns about the GPs' role in coordination with child protection services. He echoed other doctors' complaints about lack of feedback from the child protection services and lack of clarity about the GP role:

> *If you refer somebody, you never get a management plan back again. There needs to be a management plan sent to everybody...where somebody was to go given this problem, and you ought to be able to identify the major problems that are going to come out of it...what tends to happen was that the case workers get overloaded so easily and then they have*

more pressing...because once somebody's seeming to calm down, everybody ignores it and thinks thank goodness that's gone.

Dr Jill McPherson was frustrated by the lack of coordination between the CHC and the child protection services with her experience with Roslyn, Bill and Jenny (appendix 1, No.6.7), who were also clients of child protection services. While they supported Bill when Roslyn left him with Jenny, she was unaware whether they knew of the partner abuse and whether any of the family members were receiving counselling or other support. She was concerned about the lack of feedback and her inability to coordinate their care. Coordination needs therefore to stretch beyond the GP clinic out to those within the wider network of family violence community based services.

5.7 Working with the wider system

Waitzkin emphasises structural impediments to human health and the difficulties doctors have including consideration of such issues as poverty, gender inequality and unemployment in medical care (Waitzkin 1991). Heise and Harvey's ecological models argue for clinicians to consider the wider environment in which the affected person exists and which may support or impede their recovery (Harvey 1996; Heise, Ellsberg et al. 1999). They advise that clinicians need to elicit and comprehend the relevant factors within the patient's wider social, cultural and political environment and work within them. Several cases above, such as both Mrs Starelli's and Mr. Connor's financial situations illustrate the need for such consideration by the GP.

Several doctors offered good examples of this ecological form of practice. Dr Rosalie McLeish, Dr Jane Norton and Dr Jill McPherson all extended their advocacy and concept of management well beyond conservative medical paradigms. With Mrs Robinson (Appendix 1, No 4.1), an older woman who was being financially abused and isolated by her husband, Dr Rosalie McLeish used her practice as a post office box, so that Mrs Robinson (only permitted to leave the house for chronic illness management) could send and receive papers necessary to prepare a case against her husband and phone her lawyers and financial counsellors.

Dr Jill McPherson talked about encouraging women back into the TAFE education system as a form of empowerment. Her support for Mrs Yusuf (illiterate and abused both as a child and adult) built on her understanding of the Turkish Kurd community's cultural interpretation of guilt and shaming, her recognition of the language problems which had bedevilled Mr Yusuf's workers' compensation case and her ability and willingness to advocate on the Yusufs' behalf to re-open and win his workers' compensation case.

Dr Jane Norton's work with Mr Connor included a willingness to advocate on his behalf with the superannuation funds for his entitlement and her wider concern for his obvious poverty. She was also alive to the limitations of the mental health services in supporting people with chronic mental illness. To work effectively, she drew on her undergraduate education and her psychiatric rounds.

5.8 Conclusion

The examples and analysis in this chapter illustrate these doctors' limited knowledge of the management principles for victimised women, but even more so those with men who abuse and the paucity of advice about the needs of children. The lack of expertise, ethical or management guidelines left some of the doctors vulnerable to ineffective and misguided practice, whilst others practised with ingenuity and intuition with little support. The GPs' beliefs and attitudes to the problem before training hampered many in their identification of women and men and inquiring about the impact of abuse on children. They undertook a range of eclectic, intuitive and pragmatic management responses to couples, women and men who present to them. This included practices from endangerment (breaking confidentiality and some couple counselling) and entrapment (prescribing women leave when they were unable to) to empowerment and advocacy strategies. A few commendable GPs practised in ecological ways extending well beyond a conservative medical paradigm to include Waitzkin's concern with the wider systemic influences on patients' lives (Waitzkin 1991).

The major management skill the GPs wished to acquire (counselling) is not yet professionally developed to the specific demands of working with any patients living with violence and most GPs had no formal counselling training, let alone that specific to partner abuse. These GPs conceived counselling in disparate ways as well as feeling unsure of the extent to which they should undertake counselling abuse patients. The GP infrastructure (a fee for service system) discouraged good practice and disadvantaged those who undertook the necessarily longer consultations. Furthermore, the strain of untrained and unsupported partner abuse counselling placed additional burdens on doctors with an already challenging caseload.

The data also demonstrates the ways in which management practice can be unconsciously informed by the GPs' gender, attitudes and beliefs.

The practices described in this chapter also indicate problems with abuse case coordination overall, particularly when the GPs in a group practice do not coordinate patient care with all members of the family or monitor changes in the safety of women and children or the lethality of male partners. In these data, an emphasis on the adult patient/doctor relationship appeared to jeopardise opportunities for GPs to explore and then manage the problems children and young people were experiencing with abuse. They illustrated that the GPs were unsure of the limits of their responsibility within the overall family violence response system (eg child protection, police and domestic violence services) and their reservations about child protection services. They therefore had few other resources from which to seek information, support or to coordinate care of their adult or young patients living with abuse.

In the next chapter I explore the impact of the training on these attitudes, beliefs and practices with all their patients in families where abuse was perpetrated.

CHAPTER SIX: TEACHING AND LEARNING ABOUT DOMESTIC VIOLENCE: THE PEDAGOGY OF INTIMATE PARTNER ABUSE AND GENERAL PRACTICE

6.1 Introduction

In this chapter, I explore the achievements, limitations and implications of the two GP CME projects, whose aims and overall objectives addressed some of the issues raised in this study. I describe the projects' experimental context in wider GP divisional development and in outlining the projects' processes, consider the impact of staff, consumer-consultants and educators' contributions and skills, an extended curriculum, the need for coordination and the considerable achievements of the two projects. I highlight the importance of challenging attitudes in GP partner abuse teaching and of counselling skills. The GPs' and various stakeholders' views about GPs partner abuse learning needs are juxtaposed with doctors' learning achievements and remaining needs. The chapter concludes with contrasting case studies of two doctors who participated in the greatest amount of training in order to illustrate the major issues related to CME and intimate partner abuse and consideration about whose needs the CME actually met.

In doing so, I draw on pre- and post-training interviews with project staff, participant GPs, longitudinal interviewees, trainers, survey data and stakeholder interviews. I move between these data and the current literature informing medical education about this issue, outlined in chapter one.

The major educational needs revealed by doctors' narrated practices in the previous chapter include a more thorough knowledge of management principles related to all family members, including couples. GPs identification and management were at times helped, but mostly hindered by unhelpful beliefs and attitudes, as well as a lack of expertise. As other CME evaluations have found, such beliefs/attitudes should be explored and challenged in a productive manner. Ethical principles, eg with confidentiality, also required more emphasis. The data reveal the complexity and contingency of partner abuse cases that GPs require the skills to manage and the critical role of counselling in most aspects of partner abuse management.

To date, evaluation of the RACGP Women and Violence training (the national GP domestic violence training provider) has highlighted specific issues. In relation to content, GPs have asked for training to include approaches with men who abuse. The evaluation found that the GPs who sought training had substantial knowledge about the issue and gained more about referral agencies. However, the training's impact on identification rates was unimpressive. The evaluation also pointed to the need to develop education for and evaluation of flexible management responses (Royal Australian College of General Practitioners 1994). By 1996, the Project found that those

GPs they had trained to be trainers had limited skills running groups and that current participant GPs reported under-confidence in inquiring about abuse as they were unsure of their counselling skills (Women and Violence Project RACGP 1996).

6.2 Two Victorian CME domestic violence training projects

The two case projects explored in detail below were developmental and truly innovative. They built from the foundations provided by the RACGP Women and Violence curriculum. As GPs had requested, they offered additional training about male perpetrators of partner abuse as well as victims. The training objectives of the two projects are summarised in Table 7 and show that they both wanted to tackle the issue at the level of the individual GP and the wider GP environment. They both aimed to teach GPs how to develop greater confidence and skills to identify and manage victimised people and those who abuse and to enhance GP knowledge of referral services for both groups.

Table 7: Training objectives of the two divisional projects

Rural training objectives	Urban training objectives
	Broadly to reduce domestic violence in the region through:
* Develop a map of services indicating appropriate referral points for both victim/survivors and perpetrators	* increasing GP knowledge of existing services for referral of victims and users of domestic violence and to increase the GPs use of these services
* provide upskilling opportunities in *recognition and detection* of patients who present with domestic violence and sexual abuse; *crisis counselling and assessment*; *managing* patients with these problems; assisting GPs to *reduce the impact of vicarious trauma*	* *increasing GP awareness* of the incidence, causes and nature of domestic violence and to increase GPs ability to *identify victims and users of abuse* as well as to enhance GP skills and confidence in *managing* such patients.
* provide for and foster GP peer review and support	*increasing the profile of domestic violence in GP surgeries (for patients), by providing information on domestic violence and community resources available to help victims and users of abuse.
* Raise the profile of the topic within the GP community.	* involving GPs in the planning and management of domestic violence services in the region, including strengthening links between local service providers and the division through establishing a project reference group.
* cross-skilling and networking opportunities for GPs and specialist services and agencies	* filling a gap in domestic violence service provision by establishing a behaviour change group for men who choose to use violence.

Resulting from a needs assessment conducted with GPs in focus group consultations, the rural project staff added sessions about child abuse, sexual assault and adult survivors of childhood

sexual abuse, coping with vicarious trauma, forensic medicine, the role of police and child protection services, crisis counselling skills and peer networking. The rural project also sought to network GPs with each other, to respond to GPs' vicarious trauma, build collaborative networks with existing support agencies and to raise the profile of the issue within the GP community.

The urban project aimed broadly to contribute to the reduction of domestic violence in the region. They also sought to raise awareness of resources for GP patients, involve GPs in policy and planning and to fill an existing service provision gap for men who abuse. Neither project included children in their goals, or an explicit reference to challenging GPs' attitudes and beliefs.

6.2.1 The development of the projects

These projects were the result of an experimental national GP strategy. In order to encourage the development of CME in the recently established GP divisions, the Commonwealth divisional grants program offered opportunities for divisions to fund CME training relevant to the needs of their GP and local community population. There was little guidance for divisions about what was expected from them. The plan was *'to let a thousand flowers bloom' (Commonwealth policy respondent)*. Neither was the GP education infrastructure ready to support their efforts, either within states or between states and federal governments.

6.2.1.1 Staffing and funding projects

The two divisions studied employed female Project Development Officers (PDO) to undertake needs assessments in the areas and help GPs to develop projects which met the identified needs. Both divisions' needs assessment exercises identified domestic violence as a health issue. Both PDOs identified a GP in either area willing to manage the project. In the urban area, two GPs who had undergone the RACGP train-the-trainer course a few years ago offered to run group training, but add a session on men. The female GP undertook to be the project manager. In the rural area, the divisional staff included those with strong educational backgrounds. The PDO, with a social science background also had community development experience. She conducted a focus group of GPs to brainstorm the methods and content of the project and identified a female GP willing to manage the project. All the staff involved expressed strong commitment to the issue.

The rural project was successful in gaining funding for a project which extended over ten months at various locations around the region in order to attract GPs from all corners of the division. The less ambitious urban project attracted less funding to conduct their proposed double sessions (one on victimised women and one about men who abuse) three times. Following the development phase undertaken by PDOs, both projects then employed female Project Officers (PO), whose job was to implement the projects. The rural PO was a former community police officer (who had intervened in domestic violence cases) and had studied family therapy after leaving the force. The urban PO was an environmental scientist studying community development, who had an interest in the issues. After they were designed and funded, both projects put together reference groups to oversee their implementation.

The rural reference group offered considerable support to the PO over the duration of the project and was strongly committed to it. A victim/survivor was included in this small group. The urban reference group was constrained by the participation of a male GP and a women's service representative, who did not approve of the approach taken by those chosen to teach about men who abuse. The technique acknowledged the abusers' history and feelings, which these reference group members thought could be used as an excuse for their abusive behaviour. They also objected to the allocation of funding to a men's behaviour change group without sufficient individual attention to female victims. As the reference group was informed of the approach after the decision about trainers had been taken, support for women was increased, but the training approach remained the same.

6.2.1.2 Finding teachers and developing curricula

There were no project development guidelines for GP project managers about their responsibilities, which included overseeing the project officer, finding training staff, developing curricula, working with reference groups and evaluating projects. Neither GP project managers nor the PDOs or POs had any teaching experience.

In the urban area, the GP project manager and her male colleague decided they would conduct the RACGP session, but update it with recent US undergraduate material. The urban manager approached a regional Community Health Centre (CHC) which funded a family violence treatment program. Two staff members, a male psychologist and community health nurse, were willing to teach GPs about men who abuse, as they were interested in expanding referrals to the program from family doctors. Together they ran men's behaviour change groups and provided individual counselling for men and women and support groups for female partners. More recently, they had added support groups for children on a trial basis. As their approach to male abusers did not meet the approval of some radical urban reference group members, there was heated debate on the urban reference group. The GP project manager observed that without having any expertise in the area:

> *That was difficult, me not knowing the political situation around the men's work, and having no idea that there were these polarised groups and working with one end [the trainer] and then having someone from the other end on the project reference group, [it] was a recipe for problems, which I didn't realise. (Urban GP manager)*

The PO was responsible for the recruitment strategy, resource development and location management. The sessions were held at the hospital base of the division. There was no further assistance for the urban staff in their teaching, other than their own experience, reading and the RACGP half-day training.

The same CHC workers provided training around men using violence to both divisions. They admitted they knew little about GP practice with men who abuse, however they had conducted many training sessions for other community workers about men who abuse and were therefore familiar with adult learning principles. They rapidly devised an experiential curriculum, which aimed to teach GPs first to identify and be motivated to engage with men and then to manage or refer them. To commence, they designed methods to prevent doctors from distancing abusive male patients and then considered methods for GPs to challenge men about their behaviour supportively:

> *If you don't unpack what these guys [men who abuse] are really on about, what's inside and how that connects with what's inside all of us as human beings, then my experience is that people will still tend to marginalise in their head and they'll still tend to stereotype them and then they'll go after causal explanations, you know, why does he do it, why does he behave like this?.. You have to discriminate between supporting the person, engaging, caring for the person, but absolutely being ruthless about the behaviour, and the men appreciate that...It becomes a lived distinction, you know, if someone cares for me but they challenge me, that's a different experience, than if I am marginalised and judged. (Male domestic violence worker with men)*

In the rural area, the division had been generally successful at gaining funding. With several senior staff with educational backgrounds, all the projects they had designed were funded, which meant they had many projects at the one time. Their previous CME project had won a national GP award. Their consultative style, running focus groups, ensured that they were clear about their members' needs and the PDO was a good submission writer who enjoyed her position.

The PO was occasionally overwhelmed by her task. She consulted with her GP project manager, but was largely responsible for the direction of the curriculum topics. She contracted staff for the separate up-skilling sessions, drawing on her own and the reference group's networks. They employed the RACGP WAV trainer to conduct the female victim sessions. With a demanding time-line (she was a part-time worker with small children) the PO was responsible for arranging the networking meetings and the development of the resource maps. She was also in charge of sessional evaluations and seeking additional drug company funding for the sessions, which was initially difficult but in which she finally succeeded.

No one undertook to see that the curriculum was coordinated nor could the teachers compare strategies. Each trainer was responsible for the curriculum in her/his separate module. The PO was pleased at the eagerness of specialists to address GPs, but was not able to ensure any consistency of teaching styles or clear overall direction in her briefings to trainers. As a practising doctor, the GP project manager did not have the educational skills for this task either.

Thus both projects, while extending their aims and objectives well beyond that previously offered by the WAV project, were nevertheless developed and implemented by staff who were not always expert in intimate partner abuse nor in educational strategies, all in a context both experimental and unready to assist. The rural project was ambitious in scope, but responsive to GPs' felt needs and with more experienced staff. The urban project benefited from a previously tested teaching strategy for victims, but hampered by dissent on the reference group about aspects of the project designed prior to the reference group's formation.

6.2.1.3 Recruitment and participation

Both divisions had several other CME projects vying for GPs' attention. The urban division contained 420 GPs (47% female) and had a divisional membership of 294. Through the divisional newsletter, the staff asked for GPs to register an interest in either attending a course on domestic violence or men's anger management. After initial interest from over 40 GPs, they then placed an advertisement for the specific two-part course in the division's newsletter. They had planned to run the victim and perpetrator workshops three times, with 10-15 GPs attending each time. In the event, despite the initial interest, only 17 (4% of GPs, 5.7% of members) attended both sessions in May and July 1997 and two GPs attended one session only.

The rural division consisted of 142 GPs (27% female) with a membership of 97 (also 27% female). The training sessions ran from May 1997 to February 1998. The PO invited all GPs, whether project participants, divisional members or not in the area to attend networking meetings and informed all practice managers of upskilling meetings each time. Each upcoming session was re-advertised at the current one. As part of their goal was peer support and networking, the staff aimed to involve as many GPs as possible, by talking to them and offering as much information as they could:

> *It's actually personal stuff, and that's time consuming and really important... So finding every tiny way to keep people, to attend to their need to participate or give them a sense of belonging and inclusion [is important]. (Rural PDO)*

From 11-25 (average 16) GPs attended each of the ten upskilling sessions, which corresponded to 11% of the division's doctors. The PO identified that 67 GPs participated in at least one of the networking meetings held in the various sectors of the region. This represented 47% of the division's GPs. Sixty-eight representatives of specialist service agencies participated in the network meetings to introduce themselves and their agencies to GPs. On average each rural participant attended 4.4 sessions.

These figures highlight a paradox. It is difficult to recruit GPs to train in a topic in which, without training they do not identify many abused patients, and therefore do not see a need to train. There are many other barriers described in previous chapters also preventing GPs wishing to be confronted by partner abuse. In these data, 15 GPs came to all the training in the urban area and 16

on average came to 4.4 sessions in the country. Overall, these are small numbers of doctors, although they could be regarded as a vanguard.

6.3 Learning goals

These courses targeted practising GPs. Only one GP of the 28 participants had any training in domestic violence. Two male GPs had undertaken some training on sexual assault and a female GP had provided forensic consultancy to a sexual assault service. All the GPs who sought training had seen women who had disclosed to them and were concerned to improve their skills.

6.3.1 What GPs wanted to learn (felt needs)

In their pre-training interviews, GPs outlined what they hoped to learn in the courses. Table 8 outlines these felt needs. The figures in parenthesis refer to the number of GPs who said they wished to learn the topic.

Table 8: GPs' felt needs for skills and knowledge about domestic violence.

1. More agencies to which to refer (11)
2. Heightened awareness and greater identification of women (10, seven rural, three urban)
    - Learning what questions to ask (4)
    - Increasing disclosure (3)
3. Increased management skills (8, two specified management protocols)
4. Increased counselling skills (7, five of these rural)
5. The opportunity to compare management strategies with other doctors (7, five of these urban).
6. Increased confidence (6, five urban or female)
7. Knowledge of legal options (4)
8. How to work with men (4, three male)

These data represent the responses of twenty-eight GPs and there is no one overwhelming felt need, which may reflect GPs at different skill levels. The most popular need was for more skills to identify female patients and then agencies to which to refer rather than a need to counsel and manage them. The fact that five rural doctors specified counselling may reflect the fact that crisis counselling was advertised as a learning opportunity, because the majority of rural respondents cited it as the highest learning priority in the rural pre-training survey. It may also reflect the fact that rural GPs counsel more often in the absence of alternative counselling services. A few GPs

spoke directly about motivating change, with a few others talking of a 'holding strategy'. Two female GPs wanted to enhance their empowerment or self-esteem building strategies or management strategies after women had separated.

Four wished to learn about working with male patients and one doctor only, Dr Peter Greenway, wanted to learn better strategies to work with children.

6.3.2 What stakeholders wanted them to learn

Stakeholders had different concepts of what GPs needed to learn. These in turn differed according to whether they had experienced victimisation or perpetration or were professional workers.

6.3.2.1 What women wanted of GPs

From Jan Pahl's first study in 1979 to my own in 1995, the expressed needs of women for GP care have been consistent (Pahl 1979; Taft, 1995; Head and Taft 1995). The majority of seriously abused women in my study first and foremost wanted the doctor to be supportive. This included sensitive communication and questioning, listening and believing, providing good referrals and follow-up, checking that women kept appointments, caring to call back and following right through until she felt strong again.

They required doctors to be able to make appropriate referrals. Some women wanted GPs to help all the family, not only themselves, because they understood how children suffered and some believed that their partners needed help also. As these studies have been of refuge/clinical samples, they express the needs of seriously abused women. However, there is no reason why the needs of others would be different.

6.3.2.2 What men who abuse thought GPs should learn

Men in the abuser group wanted GPs they could trust. They recommended GPs be challenging and respectful, ask directly about abuse and have the skills to challenge their minimisation of the problem. They also required GPs to know about men's referral services and be persistent about appropriate referrals. They advised doctors to have material in the waiting room to signal that s/he is ready to help and knows what to do, although they might deny they were *'that kind of person'*. They also spoke of the importance of doctors inquiring about progress, giving encouragement, hope and praise when they were achieving it. They wanted the doctor to support their female partners and help their children, although they reflected on the dangers for the doctor in overt action:

> *[If violence had been reported to police by GP] When I was violent, if that had of happened to me, I would have frigging killed the doctor, killed K [his wife], killed the kids, so I could see the dilemma that the doctor faces, because if he does something, he's damned if he does and he's damned if he doesn't. The problem is, it would have happened anyway, so he might as well. (Barry)*

6.3.2.3 Domestic violence workers with women

Domestic violence workers stressed the necessity to challenge doctors' attitudes and to:

> *Provide GPs with an opportunity first of all to explore their own belief systems about domestic violence and think about some barriers for them in responding. I mean doing it in a safe way because that's sometimes what stops people moving ahead (Violence against women trainers)*

They wanted doctors to reflect on the centrality of their role in providing women with hope. They recognised that doctors would need skills which could be called into play quickly, as they have little time. They did not see the need for doctors to be counsellors as they should refer to more skilled and experienced counsellors who have proper support and debriefing. They suggested that doctors would need about two days to learn the necessary skills.

They believed the second most important teaching goal after a supportive response to disclosure would be learning an effective process of referral:

> *Facilitate a connection between the client and the organisation to which they're referring... women have a whole well of fears when they've been given a phone number... Even saying, how do you think you'll go in ringing this number? Do you think that you're ready to do it? So even a couple of minutes on, asking a few questions on the barriers for the woman to take up the referral would be really helpful and just having two or three pamphlets on some of the organisations that a doctor would be referring to is really vital.*

6.3.2.4 Domestic violence workers with men

Male and female workers with men stressed that a first learning priority should be the woman's safety, then informing and empowering her to change. GPs should be open to the possibility of violence, their role in offering hope of potential change to men and women and to be skilled in challenging men's minimisation. They need awareness of symptoms and men's common minimising language eg problems with 'anger' or 'the missus'. We should teach doctors about the spectrum of controlling behaviours men use and to locate the problem with the abuser's behaviours. Like workers, GPs should be encouraged to take a value position that violence is not OK. They wanted doctors to be discouraged from medicating the problem or referring men to psychiatrists, unless they had a serious clinical illness as men can think their madness is the cause of the abuse. They recognised doctors could be an important source of encouragement for men to accept responsibility, which they prioritised as the first, most important step in the change process. GPs could help by:

> *Acknowledging their bravery... Sometimes too when the group's offered, or some further intervention's offered and they say, no. I acknowledge that, but I always add the question, when do you think you might be ready? And they don't often answer, but I think it sort of*

means that I haven't shut the door on them, I haven't let them go and whenever they're ready I'm there. Because there's no one answer to getting them there. (Domestic violence worker with men).

Workers thought that GPs needed to understand where they fitted in *'the spectrum of support'*. They would need to be aware of and have up-to-date knowledge of the resources and referral agencies offering properly accredited men's behaviour change groups.

6.3.2.5 Bilingual domestic violence workers

Bilingual workers wanted GPs to be taught that most partner abuse issues are similar for most women, therefore culture should never be an excuse for a woman's victimisation or a man's abusive behaviour. Doctors should reassure both young and older NESB patients of their confidentiality and trust and offer understanding and alternatives if female patients prefer to see a woman doctor. Female patients may not be aware of any of their options, no matter how long they may have lived in Australia. GPs could inform women of post-separation financial support, that domestic assault is criminal and that legal restraint is possible. Some women may not want to prosecute for fear of police, racism or immigration status. Many women may not prefer separating because they fear losing their children, divorce or family shame, but they still want the violence to stop. GPs must know the limits of support agencies' capabilities so that they can refer appropriately. They need to explain the agency's workings for her and could de-stigmatise the idea of counselling if she is fearful of it. Occasionally, referral to a community organisation to break her isolation may be all she needs. They urged flexibility and sensitivity to women's differences, rather than cultural stereotyping.

To summarise, there were substantial differences between GPs' felt needs and what stakeholders believed they should learn. GPs emphasised increased knowledge and skills to identify and refer victimised women, with counselling being rural GPs most specific need. This could incorporate the workers' emphasis on women's safety, trust and confidentiality. Workers with women however, stressed that GPs needed to start with their own attitudes and beliefs as these could be significant barriers to behaviour change. While all stakeholders wished GPs to learn about referral agencies, women's workers suggested that specific strategies needed to be taught for such referrals to be successful and men's workers that GPs should be persistent with encouraging and monitoring referrals. Bilingual workers stressed that GPs in diverse communities learn about flexibility and sensitivity to the particular needs of culturally diverse women and their families. Victimised women, men who abused and men's workers all felt that GPs should learn how to identify, challenge and refer men who abuse appropriately. Unsurprisingly, given the attitudes revealed in the previous chapters, very few GPs prioritised a need to learn to learn about men who abuse and only one felt a need to work with children. Professional stakeholders focussed on the need for GPs to learn about women and men, but not children. The women and men themselves wanted GPs to learn how to help their children.

6.4 Doctors' learning preferences

Doctors who participated in this study had several preferred learning styles. The majority (14) preferred a case study approach followed by those (12) who wanted small group discussions. Six doctors added that they would appreciate feedback from 'experts' in a small group discussion about cases or about their role-plays. Role-plays overall were more ambiguously regarded. Ten suggested that they would learn from role-plays, but two of the ten said that they should do role-plays, but didn't like them. Three rural doctors asked to learn from victim/survivors testimony:

> *Somebody who's survived say, 10 or 15 years of violence and then made the decision to leave and can pass onto people who want to be carers what was going through their mind. What was the psychology of why they stayed and why they left and what made the difference in crossing that hurdle in between staying and leaving? (Dr Jane Norton)*

Networking and comparing strategies about cases was very popular with rural doctors as it was with urban GPs who were motivated by the possibility. Five rural doctors specifically mentioned the value of listening and comparing with peers.

6.5 Implementing innovative training about partner abuse

While both projects consulted with community based organisations about their topics, neither project chose to teach collaboratively with agency staff. In the rural project, agency staff taught in some sessions, but not together with GPs. The first notable distinction between the two projects was their location. The higher funding in the rural project, supplemented by pharmaceutical money, allowed the rural project to hold their training in very comfortable, generously catered locations, unlike the spartan hospital seminar room accommodating the urban project.

6.5.1 The urban teaching.

The two GP trainers followed the RACGP Women and Violence training curriculum (outlined above) including a viewing of the College's video around effective consultations. There was little time for feedback or discussion. Despite the fact that both trainers emphasised listening, supporting and believing, some time in both victim sessions was spent discussing female provocation, raised by two male GPs. Several of the doctors in the second group, such as Dr Jill McPherson, demonstrated considerable experience in and knowledge of the range of cases in comparison with the two presenters, who did not present a confident 'expert' stance, but one of learning themselves. Dr McPherson's personal narrative about breaking confidentiality (Appendix 1. No 6.2) had a powerful effect on her listeners. In the two hours available, there was no time for other case studies, any cross-cultural or longer-term management strategies. In the second round of victim sessions, in response to a query from the first, staff distributed a useful manual on domestic violence prepared by the Islamic Women's Welfare Council. While referral was discussed, strategies for maximising effective referral were not included.

The GP project manager was well aware of the strengths and weaknesses of the victim session. She reflected that if she had the time, she would have first liked to contextualise abuse in the broader society and communities and then locate the medical profession's position. She believed that identification was well taught, but that she needed more time to discuss the detail of effective responses to different groups. In hindsight, she regretted only having time to merely mention children's safety.

In the perpetrator session, the male psychologist, who had extensive training experience, (although only once previously with GPs) felt he was '*winging it*'. He was clear he wanted to challenge GP attitudes to men and that the process had to be experiential:

> *The purpose is to get everybody on the boat together in terms of how they see these guys so that they can begin to intervene in a more consistent way...much more self-awareness of how they are somewhat similar to these guys...to see them as human beings with all the same kinds of ambivalence and opportunities for motivation...One of the outcomes I'm looking for is that they start to look at their male patients differently... not just violence, that they start to look at this question of masculinity and men's health a little bit more.*

He commenced immediately with GPs' own attitudes and experience. The way in which he did this was to ask GPs to recall their own experiences of abusing someone and remember their feelings about themselves and if and where they sought help. Women recalled their overwhelming tiredness and loss of control with small children. Men also spoke of abusing children, other family members or pets. The trainers succeeded in stimulating GPs to recognise their own potential for abuse and their feelings of shame and guilt. He also asked for adjectives describing victims and perpetrators, which he juxtaposed on the whiteboard. He then compared their female and male stereotypes, suggesting that men actually felt powerless, out of control etc almost as much as women and compared these with the GPs' own feelings. He did not clarify the difference between empathy and sympathy towards men but did stress issues of safety for women and children. He had too little time to teach 'funnelling' questions, which could challenge men's minimisation.

He universalised characteristics of men who abuse from his CHC client population and gave a handout, seeking to dispel popular myths. He was a powerful and charismatic speaker and drew extensively from his work with men, impressing participants as an 'expert'. He felt, nevertheless, hampered by the shortness of the session and the complexity of the task:

> *With one of those groups we had an Indian male doctor. We had three very powerful potential cultures sitting in the room, and we don't even know exactly which culture of Indian-ness, which culture of maleness, which culture of doctor-ness until we begin to unpack it a bit... The problem is that it's a very short time frame to skill somebody up. That's a fact of life. I've trained people in two days extensive training where by the end of*

that they're really starting to get, really got it, but, two hours, you know, whatever it is, it is a big ask.

He felt unable to deal adequately with the overlap and cross-referral issues for GPs when they manage both men who abuse and their partners.

Another aspect of this session made a strong impression on GPs. A personal narrative from Barry, the ex-abusive man (who had returned five times to behaviour change groups) was also a part of these two training rounds. Barry was a working class man who had been generally violent and could fit the stereotype of an abuser. He was a powerful, seductive speaker, who spoke openly about his enjoyment of violence, 'the familiar dance' and how he had struggled with the need to tell someone and his fear of telling. He had seen several GPs, but disclosed his violence to none of them. The GPs were fascinated by him. The session closed with a role-play between two GPs, one playing a male patient discussing anger with the other GP. There was no time for feedback around the role-plays, discussion of different types of abusers, GPs' own male patients or comparison of GP strategies with men. While referral to behaviour change groups was recommended, there was no discussion about the potential effectiveness of different men's groups or which men should be referred or those who should not. Thus the major emphasis of the session was breaking down the communicative distance.

The urban GP project manager, aware that the RACGP project needed to be supplemented with training about both men and children, reflected:

> *It would be good to have a central training package that was available... a quality package, well researched, that had been focus tested, in terms of its educational value, because it seems to me that still we are working very much in isolation. And that divisions are doing these projects and re-inventing the wheel all over the place, and I think overall that's a bit of a waste of time and money and effort. You may still have that training package presented by local people if that was thought to be more effective and likely to get people to come along. (Urban GP project manager)*

There were short breaks in these two-hour training sessions, at which sandwiches and coffee were served. It was a marked contrast to the rural sessions.

6.5.2 Rural gastronomy and partner abuse education- a comfortable mix

The launch of the extensive rural project, initially without drug company sponsorship, was co-located with another CME session on male sexual impotence and the value of intra-penile injections to restore erections, sponsored by the drug company who produced it. It was a pragmatic solution but a considerably inopportune juxtaposition. Following an introduction before dinner by the GP manager outlining domestic violence prevalence, a psychiatrist who specialised in adult sequelae of childhood sexual abuse reported on her research with GPs on this issue, using

dense overheads. She had a difficult task, facing tables of dining GPs in the space between main course and dessert.

Thereafter each of the rural sessions was held at comfortable locations in different parts of the region, allowing time for GPs to arrive early for a drink and meet and talk with their peers. It was difficult for trainers to teach, as some sessions were diverted by waiters and the timing of courses. Often the layout was not conducive to small group discussion or role-plays. Occasionally, eg with the vicarious trauma session, round tables did provide small groups for such purposes.

In a vineyard restaurant, the RACGP WAV trainer had a group of 25 arranged in a horseshoe shape. She conducted the same session as the urban trainers, but she was more confident and very experienced with groups. She explained her goals:

> *I don't want them to solve it. I want them to be able to intervene. That means listen, believe, help them with resources. You know, be willing to be with them where they're at, are they pre-contemplative, contemplative, are they ready for action. (WAV trainer)*

She referred GPs to the WAV manual, which they had only received that evening. She stressed the need not to 'blame the victim', but to be supportive. She was challenged by an older male GP about provocation, but he was challenged in turn, by both her and his peers.

In contrast, the crisis counselling session was conducted by a family systems counsellor with experience of the range of family violence, but with no knowledge of the content of other sessions. In presenting patterns of domestic violence more akin to 'common couple violence' (Johnson 1995), she contradicted the non-victim-blaming teaching in the victim session. Although, she may not have intended it, most of her session could be thought of as marital counselling. She referred to a 'common' scenario of the 'nagging wife' and retreating husband, who lost his temper and hit her. These stereotypes became the focus of discussion on the table at which I was sitting, whereupon male and female GPs discussed features of nagging women they knew, their own behaviours and the differences between men and women, according to the popular book ' Men are from Mars, Women are from Venus' (Gray, 1992).

In later parts of this session, participants viewed an American video of a family systems counsellor who integrated inter-generational patterns of learnt behaviour into her marital counselling of non-abusive couples with problems. The trainer stressed that GPs should only undertake short term counselling strategies. She also stressed that patients have the responsibility to change and GPs cannot fix the problem - it's not their job. She added that GPs shouldn't be doing the work for patients, and offered ways in which GPs could give patients written homework and facilitate counselling closure. She gave participants a handout with key learning points from her session.

In a session tangentially related to partner abuse, staff from a local sexual assault service conducted a session on rape and childhood sexual abuse, using videos, case studies and role-plays, familiarising GPs with their work and offering consultation and support.

The community health nurse conducted the male abuser session with rural GPs and Barry, the ex-abuser repeated his story. Unlike the psychologist in the urban training, she was challenged about her data referring only to the CHC clientele. Barry on the other hand, was effective again in stimulating GPs' beliefs that men may be capable of changing.

At another session, four victims described their abuse experiences and those with GPs. In this session, Dr Peter Greenway brought two of his incest survivors, including Amanda. The first of the four women had been tied up and raped by a teenage stranger. The second was raped from four years old to fourteen by her adopted father and had suffered over 30 operations until Dr Greenway asked about abuse. The third was the survivor member of the project reference group. She spoke about her doctor's sympathy for her abusive manically depressed husband. She emphasised to doctors they should not transfer their anxiety to the victim, nor consider a woman's public persona (she was a successful professional) in judging their experience of victimisation. The last woman, Amanda stressed her relief at being able to disclose her childhood abuse and how she felt desperate that her behaviour was hurting her sons and ruining her marriage. After their presentations, the GPs present talked further to women over dinner and asked them questions.

A community police officer and a senior child protection manager presented a session where they clarified their separate roles, reported cases with GPs and offered their services as both referrals and advice agencies. At another session on child abuse (on children directly physically or sexually abused and those witnessing partner abuse) a female paediatrician and her social worker colleague attempted to model a non-expert stance for GPs. They presented detailed case studies from their work at the Children's hospital in dense overheads. In this session, several older male GPs argued about the importance of physical discipline and how violence was genetically inherited - that is, some boys were born bad. Again, they were (albeit gingerly) challenged by their younger peers and the trainers.

A local GP with expertise in forensic medicine offered a very concise lesson about documentation of abuse and standards of evidence expected in court, with case examples. He explained how GPs could prepare themselves as expert witnesses and gave out a practical and clear accompanying document. The final participatory session on vicarious trauma, following a brief overhead presentation and explanation of vicarious trauma, allowed GPs at their tables to exchange individual and practice strategies and discuss how the division might support them. This was then fed back to the larger group, documented by the PO and passed on to the division.

6.5.2.1 Rural networking and cross-skilling.

In six areas of the geographically diverse rural division, the project allowed a local GP to present a case with which s/he was concerned to a group of local network agencies. After s/he had presented the features of this using overheads, each agency representative identified themselves, discussed how their agency could contribute to the care of the patient and offered feedback about the case. Everyone had a chance to mingle beforehand over lunch. Local service providers always outnumbered GPs by two to one.

6.5.3 Summary of the projects

Overall, both projects sought to teach GPs to identify female victims and men who abuse. Neither curriculum was coordinated, due to staff's limited knowledge and educational skills, however the rural curriculum topics comprehensively addressed many of the GPs' needs. Nevertheless, the lack of coordination resulted in contradictions in the attitudes taught in the rural counselling and victim sessions. The male sessions in both projects were very effective in challenging GPs attitudes to men, but could encourage collusion, without adequate time to practise appropriate management skills, such as challenging minimisation. All sessions suffered from a shortage of time to teach more effective management skills. Little of the manner in which either project was taught responded to GPs' preferences for learning (small groups and case discussions), with the exception of the rural vicarious trauma session. The consumer testimony responded to some GPs' preferences, as did the rural networking sessions. The urban sessions had the advantage that almost all participants attended both victim and perpetrator sessions, unlike the rural session where many GPs were unable to attend both. For example, none of the four rural longitudinal interviewees attended both sessions. Dr Greenway was not able to attend either one. Thus in the following assessments, GPs responded differently to their separate learning experiences.

6.6 How GPs appraised the training and its teachers

In the overseas evaluation of medical education about partner abuse, the strength of teachers and teaching methods impacted significantly on the achievements of educational goals (Birrer, Vourkas et al. 1997; Short, David et al. 1997). These were particularly noticeable in teachers' abilities to manage group dynamics (similar to the RACGP WAV project) and to model and challenge attitudes. The impact of different teachers and methods was also apparent in this study.

6.6.1 Teachers and formats

Almost all respondents in both divisions were pleased with the evening two-hour teaching sessions. Most appreciated the variety of activities and format. However, there was little scope for doctors to discuss cases or to engage in small group discussions, which was their preferred format. Rural networking sessions and the smaller numbers in the urban teaching sessions allowed doctors to learn in small groups. Rural doctors valued the socialisation of evening dinner formats, which

as Dr Rosalie McLeish appreciated, broke their professional isolation. The rural staff's emphasis on inclusion paid dividends in GP participation and achieving peer support and networking.

Respondents had a range of views about teachers. These differences emerged around who was perceived to be 'an expert' on these topics and how they were perceived to have performed. The success of the strategies for teaching about men who abuse seemed to reflect doctors' perceptions that the male psychologist (who has been working with men for many years) knew what he was talking about and was a confident speaker. He performed as an 'expert'.

In contrast, the equally expert paediatric teacher specifically chose to model a non-expert stance. She was less successful at persuading doctors that her data from peer-reviewed journals was valid, whereas data from the psychologist's own practice was not challenged until presented in the rural session by his less 'expert' female nurse colleague. The RACGP female victim trainer spoke about the importance of a non-expert position with women and gave doctors both expert and non-expert role-plays in which they themselves could practise different stances, but was perceived to be expert herself, in the scope of her knowledge and teaching skills. Both the urban GP trainers and participants perceived the two GP trainers as less expert than Dr McPherson and others in the group and were less positive about the urban victim training than the abuser session.

Doctors were very enthusiastic about the role of consumers and those sessions were rated very highly. Some suggested that role-plays would be more effective if conducted with consultant victim/survivors and men who had abused, such as Barry, as the feedback would be better informed than that from fellow doctors. A similar strategy, receiving role-play feedback from a standardised patient, was valued by US medical students learning about male partner abuse (Short, David et al. 1997).

Educationally then, the GP participants emphasised that they greatly valued trainers perceived as 'expert' in knowledge and experience and consumers who recounted their experiences with GPs (and who could offer direct feedback about GPs consulting styles). Doctors also valued the chance to exchange strategies in small group discussions and discuss cases with which they were concerned.

6.6.2 Attitudinal change about identification and management

Both in previous evaluations and from women's workers' assessments, GPs' attitudes to the issue and those involved were critical to their behaviour change. Similar to the RACGP national evaluations, GPs' attitudinal changes were relevant to their learning achievements. Attitudes affecting inquiry and management present in these GPs' consultations were not tackled by this training, except for those which were barriers to working with men.

In previous chapters I outlined how longitudinal interviewees' attitudes affected their practice. Even after training, Dr Jane Norton reflected that although she felt a bit more confident, the problem remained an ugly and difficult one for her. Dr Harold Rosario retained his views about

couples he was treating and the importance of advising women to leave. Dr Errol Threadgold's views about couples, blue-collar workers and violence were not challenged. Dr Greenway's attitudes were not challenged, as he was unable to attend the sessions on either women or men.

The two consumer sessions (victims and perpetrator) made powerful impacts on those GPs who attended. They were both rated highly. Rural GPs reported greater awareness of victims' feelings, the range of presentations and the need to ask directly. The overall majority of participants reported that their attitudes to and identification of men who abuse was now more positive. Whereas previously they would not have, now they felt motivated to engage with men, as they believed that men could change and knew they were able to refer to behaviour change groups. The impact of the male abuser session was strikingly illustrated in the urban survey by the changes in comfort levels of urban participants about working with men who abuse, which are summarised in Table 9.

Table 9: Urban GPs feelings towards working with men before and after abuser training

Respondents before training N=15	Respondents after training N=11
0% 'completely comfortable'	18% 'completely comfortable'
0% 'quite comfortable'	46% 'quite comfortable'
20% 'just comfortable'	27% 'just comfortable'
60% 'not very comfortable'	9% 'not very comfortable'
20% 'not at all comfortable'	0% 'not at all comfortable'

The qualifications made about this session were from an urban male GP who felt an '*unwilling voyeur*' to the abuser testimony and another who queried the representativeness of the generally violent consumer, in contrast to others he was aware of:

> *I would have liked to see somebody in a suit and tie, where he's been abusing his wife, either emotionally or physically,[on the] outside a very well known, or famous or very polite, talkative [man], and then the other side in the house, that would have been a good example. (Urban male 11)*

While GPs in both areas said that they were more likely to raise abuse with men, in the surveys, some other attitudes to men had not changed. Suggesting stereotyping, 45% of urban participants (cf 10% rural) still thought men using violence would be generally aggressive. Similarly, over 30% of rural respondents thought alcohol was the overwhelming cause of partner abuse, compared with 13% in the city. When approaching men to challenge their abuse, 91% of the urban sample thought it never appropriate to break confidentiality (perhaps reflecting the teaching power of Dr Jill McPherson's own narrative). In the rural area, although they were not asked prior to the CME, 24% of respondents still thought this permissible and 24% expressed uncertainty.

Other post-training attitudes reflected doctors' lack of understanding of the victim's position. After training, some doctors asked their female patients directly about abuse and were shocked at their patients' subsequent first disclosure. Some of these doctors appeared to criticise women for not disclosing earlier and regarded their previous non-disclosure as a form of lying. One rural doctor spoke somewhat dismissively of his female patient of ten years as *'someone [who]'s declared themselves to be a battered wife'*. More sympathetically, an older urban doctor, when he discovered his patient of many years had been experiencing weekly assaults, reflected:

> *I thought she was happily married. She is a person I've known for about nine years, and I've never suspected it at all. And I've, when I think back, I would have seen about nearly four years of the same sort of story, of not telling me quite 100% of the truth. (Urban male 4)*

In the survey data below, similar attitudes and beliefs to those found in the RACGP post-training survey remained in both areas. These indicated that doctors still believed the best advice they could give a woman was to leave and that marital counselling is advisable practice when male partners are violent. In the rural area, a proportion of respondents will not have attended the training about victims, but this is not the case in the urban area. Rural GP responses may reflect the counselling training. These data are summarised in Table 10 below.

Table 10: Percentage of respondents answering with preferred responses to management practice

Pre and post-training survey questions	Urban		Rural	
	Before	After	Before	After
The best advice to offer a woman in an domestically violent situation will almost always be to leave (disagree)	53	64	33	47
Relationship counselling works well for the majority of couples where the man is violent (disagree)	40	55	Not asked	47

The fact that unhelpful attitudes to victims or beliefs about management were not challenged, and those toward men challenged so that GPs felt willing to engage (but would only look for certain types of men and not others) is reflected in further reported learning achievements.

6.7 Learning achievements in identification and detection of partner abuse

From the survey data, participants in both divisions made gains in their knowledge of published prevalence rates, although urban participants were less well informed to begin with. In both surveys, GPs reported an enhanced understanding of presenting symptoms in both women and men. In their oral feedback, several urban GPs commented that the prevalence surprised them. All doctors appreciated gaining knowledge about further resources, particularly those about male

referral services. Rural GPs reported that they had learnt more presenting symptoms for all forms of abuse in children, were more aware of them and this was confirmed in survey data. The urban respondents were more persuaded that child abuse is common in families with domestic violence than their rural colleagues, but not all rural respondents attended the child abuse session.

It is quite difficult to assess with any accuracy, the effect of this knowledge on GP behaviour. These doctors reported gaining confidence through the learning, but were more able to recall new disclosures, which were fewer (most of whom were longstanding patients, whom they had now asked) than their rates of inquiry. It is a concern that GPs may be more motivated to identify both victims and perpetrators, but hold inadvisable attitudes to management.

6.7.1 Increasing detection in the country

The overall majority of GPs reported feeling more confident to identify female victims and many said they would ask directly. However, many found it difficult to translate this into altered behaviour.

The profile of the project did raise GPs' awareness of the problem overall. Several rural GPs commented that they felt more confident and aware, but most said that they were not detecting more abuse than they had previously. The rural GP project manager, who attended all ten sessions (and all networking sessions), reported asking about abuse more frequently and identifying more victimised women. Of the three rural participants who attended the VAW victim workshop, one reported no further cases, one was unsure and the other reported one new case. Excluding the two profiled in detail below, eight of the twelve rural respondents (including the four case interviewees) did not attend the VAW victim session. Dr Sally Morris, Dr Rosalie McLeish, and Dr Jane Norton identified one or two new cases. Dr Peter Greenway did not. None of the remaining four rural respondents reported increased identification, although two already had high detection rates. Of those who identified further victims, many said that these were women who disclosed abuse in their past. In total, five of the twelve rural participants reported modest increases, despite more of these not attending victim specific training. At the end of training, with additional resources, confidence and skills, Dr Jane Norton added this reflection:

> *Sometimes I still do forget [to ask] and it surprises me that it's a problem...Its a fairly ugly topic...even me...fairly open to ugly topics has a limit to how much you can swallow about it...I would have thought the main problems with me were lack of resources and skills on how to deal with it, rather than not wanting to deal with it.*

Four of the twelve rural participants attended the session on men who abuse, including Dr Greenway and Dr Morris. Neither identified new cases as a result of training, although Dr Morris was able to assist her registrar with an appropriate referral for a couple, where the remorseful man and his partner, Mr. and Mrs Nicholls (Appendix 1No 3.3) wished some change. Dr McLeish did not attend, but doesn't see many men, whereas Dr Norton who did not attend, identified two new

young male cases. Of the remaining eight respondents, one GP (Rural male 14) already saw men who abused, to whom he was fairly hostile but with whom he became more willing to engage after training. The GP project manager did report seeing more men who blamed their marital problems on their wives and was happy to refer them. None of the other six GPs, two of whom attended training, identified further abusers. One who had not attended, (Rural male 6) confided that he was still fearful of attracting a violent response from men, but would be happy to refer.

6.7.2 Increasing detection in the city.

In the urban area, seven of the fifteen GPs (excluding case interviewees) identified existing patients as victims, through direct questioning. In one case, an older male GP was shocked to discover a woman he had been seeing for nine years had been experiencing regular physical abuse.

> *One woman I had, she was a bit fidgety but not very much and after about ten minutes I thought, you do want to tell me something... And I just asked her, are you happy in your marriage? Which I normally ask anyway. Oh, yeah. I said, does your husband beat you up? Does he raise his hand, slap you, that sort of thing? And I don't know, I think I was more taken back by the answer I received, but, Yes, he did this. And how often? About once a week, something like that. Related to alcohol? Yeah. And then I said, Do you want to go somewhere and talk about it? And she said, No. And that really sort of floored me. And then, this is what I said. A burden shared is a burden lessened. And I think she just purely and simply wanted someone else to know about it. And she was too afraid to tell her neighbours, and she didn't want to tell her mother. (Urban male 4)*

Both Dr McPherson and Dr Rosario asked existing women patients and uncovered previously unknown abuse. On one day following victim training, Dr McPherson asked all nine women presenting with non-acute illness about abuse and found four about whom she had not previously been aware. She already had a high identification rate and reported that she planned to ask all women presenting in her antenatal and routine women's screening clinics. Dr Rosario asked those who were separated and confirmed his previous suspicions. He said that this had been an important lesson to him, that it was part of his professional role to inquire, whereas previously he had thought that he should not ask. He did not uncover any new cases in the four-month interview period. Dr Threadgold did not uncover any new female cases over seven interviews, other than an intellectually disabled woman who presented with serious facial injuries and whose story he did not believe. When he asked directly, she disclosed that her boyfriend had beaten her. One urban GP said that she recognised female patients with suggestive symptoms but did not inquire, in some cases because male partners were accompanying them. Like many GPs, she said that time was still the greatest barrier to asking directly.

A few urban doctors said that they had recognised that some of their male patients were abusers, but that female partners did not wish the doctors to speak to their men. Other urban doctors specified culture and/or gender as remaining barriers to inquiry.

From these data, it would appear that training left doctors more confident to engage with the issue hypothetically, but barriers which prevent greater inquiry and disclosure rates with either women or men do persist. Indeed, in the rural areas, it would appear that there is no great difference in identification rates between those who attended training sessions and those who did not. In the urban areas, the important gain seems to be in identifying former and present victims among existing patients, who may have been waiting many years for their doctor to ask the question.

It is difficult to confidently conclude much about identification rates from the surveys. Some respondents dropped/altered their rates dramatically. This may have occurred after training clarified the definition for them. In addition, doctors may not have regarded existing patients whom they have now asked and who have now disclosed as 'new' victims. I previously referred to the ambiguity when women fought back or had experienced childhood victimisation and were aggressive adults. Doctors may be uncertain as to where to categorise them - in the victim, abuser or both categories.

Nevertheless, similar to the RACGP post-training survey, the reported identification gains in both divisional surveys are modest (Royal Australian College of General Practitioners 1994). In both rural and urban surveys, the majority of doctors reported seeing between one to five victims over the two to three months rose and the number who reported seeing more fell compared with rates prior to training. A few rural doctors noted their previous numbers were more than usual. The majority of urban GP respondents reported seeing between one and five men who abused and the proportion who saw higher rates of men dropped, whereas in the country, the majority of GPs dropped from seeing between one and five men who abused to seeing no men at all. Child abuse identification rates, measured by self-report in the rural survey, and covering both physical and sexual abuse, suggested a promising increase in female child abuse identification rates and a drop in those for boys.

Disclosure rates may be less appropriate outcomes to measure than the rate of inquiry (as many women may have reasons not to disclose) but several doctors commented that their inquiry rate dropped off after a few months, due to other pressures and other training. Several GPs reported that immediately after training, they identified a few more cases and then after a few months, their identification rate returned to the pre-training level. Doctors found that sustaining the improved rates was problematic without further reminder sessions. Many suggested that refresher courses should be run.

6.8 Improving management practice

What is most striking about doctors' feedback after training is the levels of confidence about management, particularly about referrals and counselling. Many appreciated learning about principles and strategies for good management of women and men. However, there were considerable differences between the urban and rural training projects in their reported achievements.

6.8.1 Enhancing management in the city

Urban GPs reported comfort from having a hypothetical framework or plan of action for victims and men who abused. This knowledge included those about the cycles of violence and the stages of change, which they could discuss with women. A few spoke openly about learning that they had unwittingly been breaking confidentiality. The GP project manager was confident that this new knowledge would *'infiltrate'* throughout all the division via the core group who attended. For some, having the RACGP WAV manual, patient resources and the resource cards handy were also valued. Thus urban GPs reported greater confidence and knowledge of resources than they had prior to training. In particular, several female GPs reported great reassurance that they did not have to 'solve' the problem, but that if they listened supportively and provided appropriate information, the responsibility for the decision belonged with the patient, not the doctor. Many urban GPs put up posters and reported their leaflets being taken from practice waiting rooms at great speed. Their patients took resources from the waiting room, but did not discuss these with doctors.

Doctors were attempting to refer both male and female patients, but few reported any success. Three female doctors reported being reassured that their supportive practices were sufficient in addition to their new referral options. Two of these women also reported assisting male partners and one felt much more comfortable managing men:

> *I have helped abusers to come to terms with what they have done is wrong and actually given them the Men's Referral Services [male abuse telephone advice line]... they did talk to them and they're still making a decision as to whether they should go or not, but I've been seeing them for counselling, listening to them and helping them. (Urban female 3)*

Two male NESB doctors reported their greatest management problems were with women from other cultures and expressed frustration that no teaching explicitly addressed these cross-cultural issues. A further two reported that time prevented them from managing the issue and that because of this it was easy *'to slip back into the old ways'*.

Of the three urban case interviewees, Dr McPherson was already experienced, knowledgeable and had high existing identification rates. She used the training to catalyse her into being more 'systematic' about identification, which she had commenced. She reported understanding abusers better after the male session and she was becoming more comfortable with engaging men. As she

worked in a CHC and had access to multi-disciplinary resources, such as bilingual workers and a skilled social worker, she was not in need of additional resources.

Dr Rosario was trying to use the referral services about which he had learnt. He had attempted to refer Mr Starelli to the men's telephone counselling service but had a negative response (they referred Mr Starelli to a lawyer, possibly because he did not accept responsibility). Dr Rosario was displeased and had then referred Mr Starelli to the new behaviour change group funded by the division, but Mr Starelli had not yet attended. He was trying to find an opportunity to give Mrs Mizzi the self-help book about men who abuse, 'Mirrors, Windows and Doors' (but not Mrs Starelli) to teach her that her husband was abusive and she should not tolerate it. He gave both women the information booklet for victims. He had not managed to convince any of his patients to take up referral options.

Dr Errol Threadgold spoke of using the one message he had carried away from training, that of the hiatus between anger and violence where a man can make a choice about action. Dr Threadgold used this concept to counsel Jack that he had choices about controlling his violence. He did not think he had gained anything further from training and did not report further gains in using resources or referral agencies. However, with a heightened awareness, he had challenged a new male patient whose minimisation he was alert to and with whom he discussed referral for counselling, but the man did not return.

Urban GPs reported feeling more reassured and confident in their practice, through learning about management principles and a greater number of referral options than they previously knew. However, for most the use remains hypothetical. Both rural and urban GPs were taught about services, but not techniques to maximise successful referrals. Therefore, the majority of urban GPs knew about, but few were as yet successful with new referrals to newly discovered agencies two months after training. Several GPs regretted the lack of cross-cultural teaching as the area contained a complex melting-pot of immigrant communities. The urban GP project manager also expressed frustration with perceived fragmentation of the partner abuse service system and the difficulty of making appropriate referrals across GP and health system boundaries.

6.8.2 Enhancing management in the country

As their training extended for a much longer period, rural doctors had more time in which to attempt referrals. They spoke about the value of increased referrals and resources, but more about counselling, which was a focus of their training and previous projects. Of the seven GPs (excluding the four longitudinal interviewees and the GP project manager), only two had used referrals. One used her resources list, which included a checklist, as a management protocol. Of the longitudinal interviewees, Dr McLeish valued not only those new agencies she learnt of on printed resources lists, but those she met through the networking sessions. She commented:

I would never have thought of approaching them directly...and in fact one I approached a couple of times and they were just so helpful [the community police].

Several of the rural GPs spoke of the cumulative effect of counselling training from this and other divisional projects. Two rural GPs spoke of wanting more counselling training, perhaps because they did not attend the counselling training session available. One experienced female doctor greatly valued learning about goal setting and structure in counselling, which the crisis counselling session offered her.

One well-informed, empathic female GP had learnt that Intervention Orders could be imposed on men living at home when women did not want to separate, but to stop his violence. She had encouraged the older woman to take out an order against her abusive husband, who had locked her out of her home. She did not feel better equipped, but was trying to engage more with men after training. She had little success with referrals for two older abusive men, whose wives were both fearful of them and had been threatened by them, but she reported that anti-depressant therapy helped them. Two male GPs reported feeling more comfortable managing men, but one added that he would not attempt to counsel men himself, but felt happy to refer.

Dr Greenway had only been able to attend the two consumer sessions and did not report any changes in his counselling practice, which was his major goal. Similar to Dr Greenway, another male GP, who had been through several marriages, spoke openly about problems as a supportive male working with female victims and the problems of transference:

The transference thing. I mean, I'm not a psychologist or a psychiatrist, I don't know how they deal with these things. Because I haven't trained with them, I've only read about it and experienced it myself. So I've worked out my own methods of dealing with it...To know how far being caring is towards a person, without them getting ideas that I'm more than caring. (Rural male 14)

Female rural case interviewees spoke of the comfort, reassurance and support, which the counselling sessions had offered them. Dr McLeish gained more confidence, strategies and structure in her own counselling. She was able to facilitate closure with two patients when she realised she was working harder than they were themselves. She reported great relief. She believed her new counselling strategies had assisted her to help a couple, Rose and Jethro. As she did not want to counsel both of them, she had assisted Rose to be more assertive and referred Jethro elsewhere. She also reported helping them to defuse spiralling patterns of argument.

Dr Norton was relieved to understand she did not have to solve the problem, but be supportive. She had used referral services she learnt about in the networking meeting.

In another example, the Nicholls were a couple who both came from very abusive family backgrounds (Appendix 1, No. 3.3). Like his father, Mr Nicholls was an alcoholic and clinically depressed, but he accepted responsibility for his violence and Mrs Nicholls did not want to leave,

but the violence to stop. Dr Morris supported her registrar referring Mr and Mrs Nicholls (and their children), to their newly discovered regional CHC, which offered male behaviour change groups, victim support and support for children. She had used her recent appreciation of family systems theory together with questions about the impact on the children to bring the couple to both accept the need for change. She briefly counselled both partners, drawing on their desire for their children to lead different lives, while maintaining an anti-violence stance. She was able to elicit Mrs Nicholl's level of distress and her background, where her registrar had not. She encouraged Mrs Nicholls to accept help with her past, as this was Mrs Nicholls' second adult abusive relationship. She condemned the abuse but not Mr. Nicholls and supported their effort for change. The registrar's role was to support the couple as they attended the program and to monitor their progress. He would undertake low level supportive counselling and monitor Mr Nicholl's depression medication. It was unclear how the case would be coordinated between the CHC and the registrar.

Thus, in the country, more doctors reported stronger confidence and abilities in counselling than their urban colleagues. Several GPs, particularly female, confirmed and strengthened their counselling strategies with female victims. Increased confidence was reported by both urban and rural doctors, but rural doctors provided detailed accounts of behaviour change. It appears that more rural than urban GPs have used referral options provided by the training, certainly those gained in the networking sessions. Many GPs have certainly altered both their motivation and potential management strategies with men who abuse and are pleased by this.

6.8.3 Managing stress:

In both the urban and rural areas, GPs reported that increasing their knowledge and confidence reduced stress. One of the most powerful messages for both female and male doctors was that their role was to be supportive and offer options for the woman to take control of her situation, not to solve or fix the problem. Many learnt this with great relief. However, the rural project specifically targeted stress in a training workshop and elicited doctors' views on both problems and solutions. The urban GP project manager was aware of the possible stress and expressed a wish for:

> *Some sort of central support network for GPs who are dealing with domestic violence. Because most GPs seem to say that it is stressful, most of them don't have time to be in a regular support group or something. But it would be good, and I don't know how you'd do it, but it would be nice if GPs could have someone that they could talk to if they were feeling stressed, or unsure what to do in a situation. (Urban GP project manager)*

In the rural pre-training questionnaire twelve of fourteen doctors reported stress and eleven that they would like to be involved in divisional debriefing sessions. The final upskilling session allowed doctors to share strategies to relieve stress. When asked what they believe worked best for GPs in general, most respondents referred to opportunities to debrief and the importance of peer

support networks, which were easier in a group practice. Other suggestions included a mentoring system, knowing the limits of one's capacity, structuring time out and leisure, sharing practice management, and having referral agencies to send patients to, particularly *'more available after hours services'.*

When asked what they did to relieve their own stress, many talked about debriefing with their spouses. Other doctors reported in the survey how they might better manage stress -

'muster up support for a weekly meeting'

' encourage patients to book longer consulting times'

'be rational, share responsibility, be clear who 'owns 'problem'

'increase debriefing and networking opportunities'.

Male GPs were more likely to say that working harder could take their mind off a stressful patient or event. Dr Greenway described how problematic this could be, as work could become overwhelming. One rural GP (Rural female 1) moved in the course of the study, from one large practice where she was referred many counselling cases to one of Dr Greenway's practices. She was grateful for the larger number of doctors willing to counsel and the case study breakfasts, which the practice organised once a week, where she could debrief. Several female GPs worked in group practices where it was difficult to find time to debrief as free time could be taken by drug companies and there was no structured place for debriefing. Dr Jane Norton experienced these difficulties in working with Mrs Davis.

The trauma session allowed rural GPs to share strategies and suggest some which the division could implement. The rural division reported that after training, when they held the first debriefing meeting, 22 doctors attended. The rural GP manager recently reported that after a year, these sessions continue. Dr Jane Norton informed me that she did not attend the first as she could not face more domestic violence. Thus the rural project was successful in enabling individual, group and divisional responses to the stresses of working with demanding and traumatised patients.

6.9 A comparison of two rural GP learning achievements

To further illustrate the impact of training, I have detailed below a comparison of two contrasting doctors who both undertook the majority of the extended rural training, between 16-18 hours each over ten months. The first of these was a solo male GP who was not comfortable with but interested in family violence, the second a younger female GP, already committed and engaged with victims (not male abusers) and who wished to improve her skills. These illustrate the extent of potential change in two doctors at opposite ends of a continuum of attitudes and experience in an extensive CME project.

6.9.1 Case 1- before training

Dr John Forrest (Rural male 8) is a fifty two year old full-time solo GP in a medium sized rural town. He described his patient population as older, with more men than women, but he was also one of only two doctors to do obstetrics in the town. He is a conservative man, neat and well-dressed who said he kept a professional distance from patients to prevent him becoming too involved and liable to stress. He was active in the division and sat on the division's management committee. He spoke carefully of being motivated to do the topic because he was involved with its development in the division and it seemed 'interesting'. He wanted to learn to identify more cases and to learn whether any treatment is effective. He preferred to learn by comparison of case study strategies with other GPs and a professional medical expert.

He reported seeing about three or four cases of domestic assault a year, before he attended training, but felt there were probably double that number in his practice who did not disclose to him. Dr Forrest does not directly inquire and acts on patient, rather than doctor generated options. He *'would offer the patient the freedom to mention that if they wanted to, but I wouldn't always openly explore that'*. If women disclosed, he described his previous management strategy in the following terms:

> *I would often leave that up to what the patient wants to do about it. I mean sometimes they might want to take legal action about it, in which case I would record any, certainly physical injuries, and keep careful notes of it. If they just wanted to let it be known that that was happening I would be listening to that and perhaps making some non-directive advice. It's important the patient themselves make their own choice about what they want to do. I might be treating an associated illness like depression or anxiety as well.*

Before training, he expressed great scepticism about legal action, the effects of jailing any men who abuse and about agencies with a social change agenda, particularly those to whom one might refer. He is sceptical about support agencies, particularly those with social workers and counselling who may have awareness raising agendas, as he believes that they increase feelings of guilt. He mentioned that not only men perpetrate domestic violence. He is concerned such agencies may enlarge the importance of the issue out of proportion and break up partnerships, rather than making them work. He then commented *'Which I don't think is a good result'*.

He believes being a male GP may be an advantage, as female GPs are more sensitive about the issue and refer more quickly as they are *'less confident in handling the issue'*. As a male GP:

> *I think it's probably easier to relate to men to some extent... a male abuser tends to be someone who has problems relating to women and I think they would feel in a difficult situation talking to a woman, whereas with a man it might be easier. And the male might be able to understand perhaps some of the reasons why they reacted the way they did. But not necessarily to excuse it.*

While he saw some male partners, he said he would not bring the issue up without the female partner's consent. He believed in the value of couple counselling. If a female partner disclosed, then, with more often physical but occasionally emotional abuse, he would:

> *Generally like to see them both together I think... Because I think that's far more productive. I think there would be a risk if you brought it up with a partner, that that partner would say, well I'm not coming back to you and you'd lose that contact... Well I suppose it's relationship counselling to see whether they want to continue their relationship. If so, how they can improve the way they relate to each other, or if they really reach the stage they want to separate from the relationship.*

With the lack of evidence-based treatment and some confusion over the boundaries between marital conflict and partner abuse, Dr Forrest held the view that:

> *I think it's very important before we do any treatment that we make sure it does produce better results...when perhaps the stresses that are causing some degree of physical and verbal violence are resolved, perhaps the children get a bit older and perhaps the financial situation improves or the wife goes out to work and the partnership works better, or occasionally when they separate and yet they're still friends and they share their children on a satisfactory relationship...I doubt if any good outcomes occur when someone is prosecuted or sent to jail or there's a court case.*

Dr Forrest was regarded by some GP colleagues as having conservative views and some expressed their embarrassment at his statements in training. However, he did make the time to attend eight of ten upskilling sessions (on violence against women; victim/survivors; sexual assault; crisis counselling; community police and child protection; child abuse; forensic medicine; and men who use violence – only missing the launch and vicarious trauma sessions). That is, he undertook between sixteen and twenty hours of training on domestic violence and/or sexual abuse. There were, however, no opportunities for small group discussions where his views could be safely aired in a non-threatening environment with trainers experienced to manage such a discussion.

6.9.2 Case 1- after training

Overall, Dr Forrest's initial comments about his learning reflected a view about his capacity to change, similar to some of the urban GPs:

> *I mean there's information you can take on board but may not necessarily change the way you react to situations greatly. The problem I think is doctors get into a groove of the way you've handled certain situations, then you add information to that which you usually build to reinforce the way you do things. But you may not change the way you do things.*

He spoke of learning most about how to identify children, who are affected by either incest, abuse or witnessing. I observed his careful listening and questions asked to victims, two of whom were

incest survivors. Although he challenged the paediatric trainers' analyses at the time, he referred to both the sexual abuse and child abuse sessions in which:

> *I think one became more aware of looking for where there was a problem child or a child being presented unnecessarily perhaps. And also amongst women that are presenting with different cases to think about it [child sexual abuse] as a cause.*

Added to his reflection about his capacity for change, he was also thoughtful about his appeal for victims:

> *I don't think patients with domestic violence would necessarily approach myself. I think patients [who] have a particular problem tend to choose different GPs for it now... Umm, I think they want to go more to younger more trend-orientated doctors that would be a lot more active in the way they handled it...But people vary certainly, patients do vary.*

He reflected more positively on the work of the sexual assault services, saying he did not necessarily agree with all of it, but was interested to hear more about their work and believed it would be easier to phone them for assistance. He was surprised at their openness to GPs. However, he revealed some persistent and deep-seated suspicions both about the effectiveness of post traumatic stress disorder counselling and about his fear of losing patients, which affected his decisions to refer:

> *I don't know that I've changed my viewpoint greatly on whether they're better off by referral to sexual assault units. Certainly the three women [victim/survivors] that spoke at the Golf Club indicated that they'd got something out of it. But they were probably more extreme cases I think... I've learnt about them [CASAs] I don't think I've used them very much. I'm not very good at referring people I must admit. I think it's that patients don't necessarily want to be referred. If they say they want to be referred to the sexual assault unit, I'd certainly do it...But they'll often come in and they want to talk about the problem... they want to see if they can cope with the minimum of trauma, without opening it all up. You often create more of a bigger problem to then cope with. And people don't necessarily want that.*
>
> **Q: Do you ask for feedback, if a woman's attending a CASA?*
>
> *I generally do, you very rarely get it reliably. I mean it seems that once they go there, they don't tend to come back to doctors. Well not to myself anyway...*

He also expressed frustration with some agencies' accessibility and waiting times, saying that it was off-putting, but he was impressed with CASA workers' perceived greater openness to dialogue with GPs. Despite having learnt about child abuse and saying he would be more alert to symptoms of abuse, Dr Forrest expressed concerns about child protection and police agencies. He

later referred to the need to maintain GP income and not accuse parents of child abuse if they explain injuries *'in a reasonable fashion'*. He had cases, which had not turned out satisfactorily in his view and spoke of the lack of feedback from such services and the need for cross-disciplinary re-education of workers:

> *Social workers have a very poor reputation of being able to communicate with doctors and doctors have learnt I think that social workers are not worth the time to try and communicate with them. So I think they need to change the way they teach social workers... and probably doctors.*

In relation to intimate partner abuse, although he thought that he might be more likely to identify now, he hadn't done so, ten months later. He attributed this to a lack of evidence for good practice:

> *I think it's a very variable scenario, that's the problem and... we have enough evidence that it's probably very common, we don't have enough evidence to decide when you intervene whether they're better off when you don't intervene, in a lot of cases... If they want to go to the police they would go there themselves, I think they've got to be self-motivated to some extent. And my job would be to explore the role, find out how much domestic violence is going and how much people are being hurt, whether there are children being involved and to give that person the option and to make sure that you know, people are protected, particularly minors.*

The project had not persuaded him of the value of intervention, although they raised his consciousness of safety issues for victims, particularly children and provided him with more referral options. He reported that he would suggest a wider range of options, but ultimately the decision was *'in the hands of the person'*. Even with his obstetric cases, he would not necessarily directly inquire about abuse:

> *I wouldn't tend to unless there was a psychiatric psychological problem, or they were presenting with a lot of problems that didn't add up to a physical or psychiatric diagnosis. In other words I was looking for some cause for anxiety or depression, I would then raise it. But I still find when I do raise it that most of them say no, there's not a problem.*

He repeated his view of legal interventions:

> *I doubt very rarely whether going through the courts and the legalistic process really helps the whole situation really.*

He also expressed the view, as others did, of the difficulty of retaining the information from training without regular follow-up sessions. Towards the end of Dr Forrest's honest and reflective interview he reiterated that with partner abuse *'as GPs we don't feel we can achieve very much'*. This view, along with others he holds, will continue to impact on his motivation to ask directly

about abuse. He considered that he might refer an abused patient, if he knew another GP in the division, to whom he felt could refer, whom he trusted and if he didn't feel he could offer sufficient care himself. All in all, his conclusion revealed that his deepest fears about changing his practice were not touched. He concluded, suggesting that to change involved acknowledging you may have practised unsatisfactorily for many years and that this was too threatening to one's professional self:

> *What I've achieved is higher than my expectation...it's very hard as one gets older to change behaviour...if you change behaviour you get vulnerable too...to stress and things. You might think you're doing the wrong thing. So you've got to have a very strong belief in you doing things the way you see them.*

6.9.3 Case no 2- before training

In contrast, Dr Libby Sale (Rural female 11) is a 35 year old female GP who works three-quarter time in a large group practice in another small rural town. The practice, which employs three female and four male GPs consists of predominantly younger doctors. Dr Sale has been employed there two years and her patient population consists of more women than men, but she thinks her group is a little younger than those of the other partners, as the older patients don't yet know her well enough to trust her. She estimated that she had seen about six or seven women who had experienced violence in the past year. She sought training because she felt she was only picking up what were very obvious presentations or women who disclosed freely, but she believed that she was missing many other cases. She also thought she could learn a wider range of referral options and greater counselling skills. She mused that she might be missing cases, as she was under-confident about her capacity to respond. She was not really interested in the men, as she believed they wouldn't change.

Her current management strategies, despite her low confidence, were already very skilled. That is, she told women it was a serious and common problem and that the responsibility for abuse lay with the man who abused. She checked their safety and told them about their legal rights. Although she stated that she was reasonably aware of options for women, she didn't feel she knew which services in the area were best and looked forward to the opportunity to meet and get to know the local providers. She was also under-confident about how to balance mothers' and children's needs within partner abuse - '*those sort of ethical issues that are most difficult*'.

Her learning goals included wanting to improve her identification rate and her ability to assess safety. A further goal was to improve her crisis and longer term counselling skills, as she knew that sometimes her patients couldn't access, afford or chose not to attend other services. Sometimes rural people felt stigmatised attending psychologists, but not about attending GPs she believed. She did not want to do psychoanalytic counselling, but said that:

My role is predominantly creating an environment where people feel comfortable to raise issues that are important to them, because it's really easy to chop off a line of inquiry... I think just being a sounding board is probably the best ... Those sort of techniques where somebody says something and you say, it seems to me that you're telling me, x,y,z, and they say, yeah sort of, ... that often helps people clarify what they do want or what they feel.

Role-plays, she says are hateful and she doesn't learn from them but enjoys small group discussion of case scenarios and the opportunity to debrief how she has managed. Debriefing sessions at her practice, she added, were useful. She attended seven sessions commencing with the launch; then men using violence; forensic medicine; community police and child protection; victim/survivors; crisis counselling; and vicarious trauma. She missed the child abuse, sexual assault and violence against women sessions. She also attended her local networking lunch.

6.9.4 Case no 2 - after training

Dr Sale found the two consumer sessions the most powerful in their impact on her. She was impressed with the different ways in which women had overcome their experiences, but also that:

A couple of other women who had this long story of presenting to doctors with a multitude of complaints and nobody actually identifying that that was the result of their childhood abuse and... I mean it sort of reinforced to me, to keep it always in my mind

She said she had particularly changed her attitude towards men who abuse:

I think my feeling's always been basically, why would anyone want to go back to someone who had been violent or abusing, and were these guys ever going to change... it was an example that people actually can change quite dramatically... So I probably would have been guilty of ignoring the men who had a problem, and dealing with the women, because I would have thought, well no matter what happens, that bloke's always been like that...The other thing that was interesting... the impetus for him to change, was that he saw in his son the sort of behaviours that he was displaying and it was that thing of not wanting your child to end up like you.

One important goal for Dr Sale had been to become more familiar with the quality of service providers:

My impression has always been that within the police force there's a fairly big range of responses to people, which range from very supportive to not very supportive, and I think that came out... there were a lot of services that I was vaguely aware of but there were details of those services and options that I hadn't considered previously that I became aware of.

She was positive about the use of case studies both in videos, which illustrated counselling techniques and speakers such as police and child protection talking about actual cases. They described the strategies they had used and how their interventions had been valuable to families:

> *Because sometimes you have this vision of people clumping in boots and all and making things worse so it was reassuring to see some cases where that didn't happen and things were done in a much more sensitive way.*

She felt she had acquired the knowledge about how to conduct a good forensic test if people didn't want to travel to the city to give evidence and had learnt that she could access forensic advice after hours, which she hadn't previously known. Her reported identification rate had risen, but these consisted of women who disclosed previous abuse, as well as obvious cases:

> *I do ask more and it's certainly something that's more on my differential diagnosis list. ... I'm just aware that I elicit that more often than I used to. I don't really know what it is that I'm doing differently but it's probably just that I'm more aware of it...*

Considering the reported prevalence rates, Dr Sale remained concerned that she was not picking up more current cases. The structural problem of time still meant, she said, that there were paths she did not pursue when she felt pressured. Reflecting on the counselling training, she thought there had been cumulative gains from a few projects in the division. She had attended a short project on cognitive behavioural counselling as well as the session in the abuse project. She reported that whereas she *'would have identified the problem and immediately referred, what I'm doing now which is different I think, is sitting with them a little longer'*. She believed that the advantage of her new confidence is that she gains a clearer understanding of the problem and is able to refer more appropriately. Also her patients *'don't feel they're immediately fobbed off'*. She believes that these new skills have helped her to assess the safety issues for women more clearly and offer clearer advice. However, she admitted that she does not ask about children's safety, while believing that she should. She has also used and appreciated the RACGP manual and the resource maps. She has more referral options as a result of the project:

> *I'm certainly more aware of the resources that are around.... avenues for getting accommodation or other support, or financial assistance.. And I've used them in the sense that I've shared that information with patients and said, there's this place and this place. But I mean I don't know whether they followed through with [them] or not.*

When patients do attend a referral counselling agency, she maintains overlapping counselling for a while to check that the referral is successful.

She would like to do more counselling training, as she believes the skills are useful across the whole of general practice. She is aware that she is seeing more male patients than previously and because of heightened general publicity about men's health, men are more comfortable with

questions about their health. She had referred men to men's groups, who had been *'basically sent in'* by their female partners to deal with their anger. She had asked a few men who had come in with depression about any anger outbursts. She felt a little uncomfortable about seeing men whose partners were her patients and thought if they were to return more regularly, she would refer to another GP within the practice:

> *I think it probably would have been better for the men to see someone else because I think they probably felt a bit under, like that I was more on their partner's side I think.*

Like many other doctors, she feels that having more skills and resources intrinsically reduces the stress of dealing with partner abuse, but she still debriefs regularly with colleagues in her practice, which they formally instituted some time ago. If the counselling became more traumatic, she would appreciate the division organising some formal supervision for difficult cases.

6.9.5 Summary of the two cases

In both of the above cases, these GPs have benefited from training. Both gained in their knowledge of the problem and some management strategies with which to help patients. Dr Forrest has clearly gained a heightened awareness of incest and child abuse, if not of partner abuse. However, his attitudes to marital partnerships were a barrier to diagnosing abuse, which were not challenged. His other beliefs about the legal system and the lack of evidence for effective interventions strengthened his reluctance to intervene. While he had learnt more about sexual assault services, he retained attitudinal and financial barriers to referring abused patients to the services. He was honest about his attitudes and how threatening he felt it would be to allow behavioural change. To a certain extent, he believed his lack of behavioural change was related to his age. However, neither trainers nor training allowed him a chance to discuss the issues in small groups or to compare with his peers' management strategies, which may have enabled a greater shift in behaviour.

In contrast, Dr Sale began with a more positive approach to partner abuse and she welcomed her attitudinal change to men who abuse. She commenced with many of the recommended management practices to which she added those around men. As she revealed that she was seeing an increasing number of male patients, this may mean she will detect further abusive behaviour in male patients and have additional knowledge and skills with which to manage and refer men. The accumulated counselling training in the division, which she attended, had strengthened her counselling abilities with abused patients. Dr Sale believed she was already both inquiring and detecting more female patients than she had previously. She was unable to attend the session on children. Unfortunately, although she was now aware of how the impact on children could motivate change, she did not believe she was asking about the impact of abuse on children.

It would appear from these two doctors' accounts, that training brings benefits to doctors with differing attitudes and experiences, which should flow on to patients. The limitations to the

outcomes training achieved related to teachers' capacities to enable attitudinal change, the formats allowing it, a lack of coordinated curriculum and GPs' capacity to participate in training.

6.10 Conclusion

The CME training described here provided family doctors with opportunities to increase their knowledge and skills about partner abuse and related abuses in the family. It offered GPs opportunities to hear first hand accounts from both female victims and men who abused. The rural project aimed to teach those who attended about the impact of direct and indirect abuse on children and how they might present. Both training projects responded to GPs' needs to increase their referral options and provided GPs with valued printed resources. The rural project addressed many of the GPs' felt needs, particularly around counselling.

However, these data suggest that even after training, attitudinal barriers to inquiry and management persist, combined with wider structural issues, like time. The projects had insufficient time or awareness of the need for a safe environment in which GPs could express and discuss their fears and attitudes. These training courses concentrated on enhancing knowledge and skills. These data suggest that this may have impacted on the doctors' wish to inquire and the small increase in identification rates. The diversity of teachers' pedagogical experience, lack of an opportunity for coordination and integration of the curriculum, minimal divisional and wider project support limited the important achievements made by the projects.

Whilst the urban project consisted of only two sessions and attracted fewer participants, it did have positive strengths. First the majority of participants attended both victim and abuser sessions. They were also conducted in small groups in which GPs could interact to some extent. The involvement of more experienced GPs and their opportunity to share their stories had important benefits in teaching doctors about breaking confidentiality. This responded to the GPs' desire to compare management strategies with each other. The urban project also increased doctors' confidence and reduced their stress as particularly female GPs appreciated the emphasis that they were not responsible for 'solving' the problem. The greatest variation in urban respondent feedback revealed differing perceptions of the strengths of trainers, according to their perceived expertise. The male trainer sought immediately to address doctors' attitudes to men who abuse. He was successful in increasing doctors' willingness to engage empathetically with men. This is a major lesson of these projects, as his impact was similar in both divisions.

The rural project evolved from GPs' felt needs, and because of more extensive funding, was able to address a wider range of skills, increase the overall GP participation rate and include the important foci of forensic medicine and GP vicarious trauma. The networking sessions, introducing community based agencies to local GPs and addressing a GP case study worked well to develop collaboration between the agencies and GP clinics, which was evident in the greater number of GP referrals after training. Rural doctors gained more skills and confidence in

counselling, although some might still attempt marital counselling due to the therapy taught and the lack of countervailing recommendations. In addition, rural doctors reported satisfaction with the individual and division wide response to their levels of stress.

If we consider the question addressed by this thesis about whose needs the training met, the conclusion from these data is that the training did meet many of the needs expressed by GPs. First GPs increased confidence in their ability to tackle the problem overall and many gained confidence that they could engage with men who abuse. They improved their knowledge of referral agencies, although the rural project was more successful in enabling doctors to use these services. The project did not meet the recommendations of women's workers that victim referral processes are complex and require teaching and practice to manage effectively. Neither did either project discuss the complexities of working with a couple, referring both male and female partners to agencies and the need for coordination to monitor the levels of women and children's safety. Indeed the importance of understanding the differences between types of men who abuse and the need to monitor referrals of men to behaviour change groups was not dealt with at all. Similarly, there was no time allotted in the urban project to difficulties associated with cultural diversity in patient populations and doctors reported difficulties with inquiry, disclosure and management of culturally diverse patients. In conclusion, overall the needs of doctors and men were better served by these training projects than the needs of female victims or their children.

CHAPTER SEVEN: LIFTING THE LID - DISCUSSION AND CONCLUSIONS

This thesis explores the perspectives and learning of a small self-selected group of Australian GPs concerned about their practice with patients experiencing partner abuse. It includes the views of different stakeholders and examines forms of continuing education attempting to improve GP domestic violence management. The domestic violence training offered to doctors in two Australian GP divisional projects was compared with published management principles, the GPs' opinions of the training and other stakeholders' opinions of the training. The most important contribution of the study is the light it throws on different aspects of the GP's role, not only with female victims, but also with couples, the male partner and any children. It focuses attention on the importance of counselling in GP management of psychosocial issues and, in particular, the difficulties GPs experience counselling abused and abusing patients. How male patients using abusive behaviour view and experience GPs and the broader health system are also documented. The study employed a design appropriate for a dynamic and developmental area, which included a multiplicity of mutually reinforcing research methods and opportunities for participant feedback. Its limitations lie in the data's limited generalisability and reliance on participant recall. However, the thesis highlights important findings, which contribute to a greater understanding of the problems of GP partner abuse management. Further, it proposes a reformed curriculum framework designed to improve GP education about domestic violence.

7.1 The multi-faceted abuse in Pandora's family

The health and well-being of all family members is affected by partner abuse and any one of those involved may attend GPs, whether they are abusers, victims or children who live with them. Many of the patients reported in this study may not have been seen by any other helping agencies. This highlights the unique opportunity inherent in the general practice setting for beneficial and informed intervention with each family member.

When asked about patients experiencing abuse and domestic violence prevalence in their practices, GP participants diverged in their concepts of domestic violence and in their perceptions of its scale. They also differed in their understanding of who suffered from it and who perpetrated it. They described a continuum of abuse among female patients. At one end of the continuum they identified patriarchal terrorism, at the other, partners who threw things and shouted at each other. They spoke of patients diverse in a number of dimensions: their socio-economic status, their language and cultures, their reasons for attendance, and the range of abuses they were currently or had previously experienced or perpetrated. Patients' children were also affected but largely overlooked. Doctors were unsure about the boundaries between 'normal' levels of aggression in personal relationships and violence/abuse demanding a response. The study suggests that such uncertainty about boundaries and lack of appreciation of the diversity of abuse patterns can result in many missed opportunities for support.

An important pattern evident in the doctors' narratives was their difficulties with managing couples. When seeing couples, some GPs overlooked the violence, privileged one partner over the other or broke confidentiality. Ferris et al (1997) were the first to identify the problems for GPs with what they termed the 'dual relationship' in the management of domestic violence. The 'dual relationship' has been overlooked in Australian GP domestic violence education and merits further attention.

Many other aspects of partner abuse and abuse management in Australian general practice also remain poorly understood. Until the present study, how GPs manage male patients who use abusive behaviours has been absent from Australian research. This study investigated how doctors dealt with the diversity of male patients who abused their female partners. The range of abusive behaviours among men in the study included: violence to female partners only or to partners, children and other people; physical abuse; isolation and withdrawal of money and affection. Men also varied from those who felt guilt, to men who felt justified in their behaviour, as well as men who wanted to change and those who did not.

Doctors, domestic violence workers and the men themselves described depression, drug and alcohol abuse and other associated symptoms all documented in the literature (Hamberger, Feuerbach et al. 1990). Back problems connected to stress and workers' compensation cases were also quite frequent among the men in the current study. However, any interpretation linking back problems, workers' compensation and partner abuse is speculative at this stage in the absence of more focussed research. Workers with men and men themselves spoke of the many forms of self-abuse.

Some male patients who used abusive behaviour had symptoms of psychiatric illness, although most did not. The association between mental illness and partner abuse is also found in the clinical literature (Hamberger, Lohr et al. 1996). If male patients have a psychiatric illness, doctors should consider the safety of women and children living with them. So that we can more confidently describe the characteristics of and variations among men who abuse, further population level studies are required. Most importantly, doctors need to be well informed so that they can recognise the different manifestations that partner abuse takes and the diversity among both male and female patients.

Similar to the variation in partner abuse or patients living with it, the doctors themselves also demonstrated considerable differences. Good has observed that:

> *The portrayal of a monolithic 'biomedicine' or a univocal medical 'discourse' can be juxtaposed to studies of particular medical clinics, each housing a diversity of conflicting perspectives and voices, or of individual practitioners, idiosyncratic and personally motivated while constrained by the medicine they have learned, the problems they face and the institutions in which they work. (Good and Good 1993) p.82/3*

While the diverse doctors in this study wanted to support all their patients suffering from partner abuse, before training, their lack of expertise resulted in their drawing on other sources within what Bourdieu describes as their 'habitus'. By this, Bourdieu refers to our disposition to act implicitly in ways acquired from the cumulative effects of our interactions with significant people, cultures and institutions in our particular historical environment (Bourdieu 1990). From their unique habitus, each doctor displayed both positive and negative attitudes and beliefs influencing their constructions of patients and decisions about how to manage the abuse. I have argued that these attitudes and beliefs are very important because they influence what doctors consider they are looking for, their motivation to intervene and their clinical judgment about a suitable management plan.

In Chapters Four and Five, I argue that without expertise, some doctors' beliefs and attitudes to intimate partner abuse and its subjects can be major barriers to their more effective care of patients. In some cases, patriarchal attitudes were bolstered by cultural, religious and professional attitudes. These affected how partners were constructed, which victims were perceived as 'deserving' or 'undeserving' and which men were those with whom to sympathise. In this study, although doctors empathised with their victimised female patients, some attitudes to the women inhibited better care. For example, some believed in the primacy of marital partnerships and that women preferred privacy to direct inquiry about their abuse. Doctors were reluctant to reframe male patients as men who abuse and could also exhibit hostile or distancing attitudes to men who abuse, affecting their willingness to identify them. Moreover, they held varied beliefs about causes of men's violence and about which men they should question. These attitudes could result in stereotyping, an avoidance of challenging male patients and a tendency to place greater responsibility for change upon women. These attitudes to male patients were challenged effectively in this study and proved amenable to change after training.

With many doctors, overall attitudes to the issue of partner abuse, to patient/doctor relationships with adult patients and to community child protection services contributed to overlooking the impact of partner abuse on children and an almost complete oversight of children's needs.

Similar to the findings of this research, the recent five-city US study of doctors' responses to domestic violence found that *'individual providers' prejudicial attitudes towards both victims and perpetrators'* was a widespread and significant problem inhibiting improvement in the health care system (Cohen, De Vos et al. 1997). The current study, together with the findings about GP attitudes to female patients from the RACGP WAV evaluation, suggest that uninformed, some times prejudicial GP attitudes affecting abused patient care may also exist in Australia (Royal Australian College of General Practitioners 1994).

7.2 Identification, screening and women's agency

Most doctors in this study waited for women to disclose rather than actively inquiring about partner abuse. As several other studies have found, doctors' reluctance to actively inquire is influenced in part by their attitudes to the problem, but also by the constant barrier of time and the absence of evidence-based practice (Friedman, Samet et al. 1992; Sugg and Inui 1992; Ferris 1994). This study indicates that even after the more extensive education in the rural CME project, doctors who received training to enhance clinical practice with abused patients gained greater confidence and resources, but demonstrated limited behaviour change. In Australia most doctors have received no partner abuse training or any other training which would be likely to have achieved any more than these two projects. These data have implications for any recommendation that Australian GPs routinely screen all female patients in their practices for partner abuse, when the majority are untrained and some of those who are, remain uncertain about intervention. The medical literature (with some caveats about the importance of competencies) increasingly contains recommendations for doctors to screen all female patients for domestic violence (Family Violence Prevention Fund, 1999; Elliott and Johnson 1995; Freund, Bak et al. 1996; Cole 1999).

As many doctors in the study were uninformed about the boundaries of what they were looking for, they varied in their perceptions of the numbers of victims in their patient populations. Many GPs felt that they were not identifying 'enough' cases of domestic violence in comparison with the broadly publicised figures of one in three or four women being abused. As a result, many could judge their own performance by the number of patients who disclosed to them. Consequently, some disbelieved the figures and others felt guilty and inadequate.

Gerbert at al recently challenged doctors to reconceptualise their definition of a successful outcome of screening and case finding in female patients (Gerbert, Abercrombie et al. 1999). They suggested that the focus of interest for doctors should not be the number of disclosures but the number of times they sensitively inquire about abuse. Doctors could then judge their success by how well they responded to women's denial, hints, acknowledgment or frank disclosure. As women have many reasons for not feeling able to disclose at a particular moment, even without disclosure, doctors are advised that when they only suspect abuse, they should acknowledge that abuse is wrong, affirm their worth and subsequently inquire regularly about their well being. In so doing, doctors can acknowledge women's fear or hints, and plant seeds for victims' later actions (Gerbert, Abercrombie et al. 1999).

The importance of such an approach is that success is defined as doctors' sensitive and direct inquiry and the consequent response they make to women's decisions about disclosure. In this study, some doctors felt disappointed, let down or critical of women who later disclosed to them when the doctors asked after being advised to do so in training. This may have resulted from participants not fully understanding the mire of fear, shame and self-blame which prevented women from disclosing without being asked. Such feelings can be disempowering to both doctor

and patient and unhelpful to a therapeutic relationship. The importance of such a reappraisal of the notion of screening is the value placed on women's agency and their right to disclose or not, without encountering victim-blaming for their decision.

Screening in public health has been reconceptualised from a clearly defined epidemiological concept with rates of sensitivity and specificity for disease detection to include bio-psychosocial issues. Many of these problems - suicide, child abuse and partner abuse - demand a different kind of sensitivity. As doctors and patients are diverse, it is difficult to imagine any one question which would be appropriate and accurate with all patients at any given moment as well as satisfying epidemiological screening criteria (Lawler 1996). After having reviewed the evidence for partner abuse screening, Lawler points out such a recommendation meets only one screening criterion – that abuse is a serious health issue. Unfortunately, we do not yet have any population-level evidence that GP intervention will safely reduce morbidity or mortality to satisfy the most important criterion and women's evaluations of GP care are equivocal.

Newer concepts of screening come with more of the baggage of surveillance and state and professional control over families and individuals which have been radically and effectively critiqued by Foucault amongst others (Foucault 1973). The sensitivity arises in judgment about the correct balance between the rights of individual citizens and the population health responsibilities of government and its agencies. Such tensions are found in the debates about screening for domestic violence in general practice. The major reason for inquiring about violence is the potential to reach women early and offer them the information, support and options for intervening or stopping it. Early intervention offers the potential to help children and men also.

However, identifying and 'diagnosing' victims can have detrimental effects. The first is when screening is implemented before doctors have the confidence and expertise to respond (Cole 1999). As the data in this study and other studies illustrate, poor responses can have negative consequences for the victims. (See for example, Mrs Starelli or Fatima, Appendix 1 Nos 5.1&7.2) There are further considerations. If women are assigned diagnoses of psychological illness as a result of domestic violence, their abuser can use this in courts as a reason to gain custody of the children. When doctors report children at risk from the abuser, women can be blamed by child protection agencies for not protecting their children from him and their children could be taken away. In the US, abuse identified in a woman's records can detrimentally affect her health insurance (Heise, Ellsberg et al. 1999) or put a woman at risk if there is no protocol over file management and the abuser sees the files (Cole 1999).

Nevertheless, as new US screening guidelines propose, routine screening of women over 14 (eg in antenatal clinics or drug and alcohol settings) in competent, confident and well-coordinated health agencies could be of major benefit to help victims, abusers and their children rebuild their lives (Family Violence Prevention Fund 1999). In Australian general practice, this can only be achieved however, when there are adequate services to support doctors, many more are confident and

competent, guidelines and protocols are developed and there is evidence that interventions are beneficial. We should comprehensively strengthen GP competencies and support before GPs are directed to routinely screen their entire female patient populations.

7.3 Partner abuse management in general practice

Similar to other studies, doctors in this study believed that marital counselling was useful when there was domestic violence. Some offered couple counselling themselves, some referred patients for marital counselling and others privileged family reconciliation or preservation (Royal Australian College of General Practitioners 1994; Ferris, Norton et al. 1999). I argue that this belief in the value of marital counselling arises partly from concepts learnt in their undergraduate and vocational training. General practice incorporates concepts from family medicine. There is a tension between the theories informing family medicine and those informing partner abuse. As Candib has pointed out, family medicine has been strongly influenced by family systems theory (Candib 1995). As I have discussed in Chapter Two, family systems theory tends to ignore the power dimensions of gender relations, while the most accepted models of good practice in domestic and family violence interventions draw to a considerable extent on feminist and gender theory to contextualise their practice. At an international level, many agencies have adopted definitions of intimate partner abuse acknowledging the imbalance of power between the sexes and define domestic violence as a systematic abuse of power in intimate relationships, involving coercion and control. They contextualise partner abuse in the broader patterns of violence against women across many different societies (Heise, Ellsberg et al. 1999). This perspective forms the context for advice then given to practitioners. Statements about domestic violence by Australian medical organisations most commonly reflect this feminist analysis, but tensions in everyday practice between the two theories/approaches can impact on how GPs respond to partner abuse/domestic violence among patients and whether they intervene or not, or offer marital counselling and reconciliation or not.

7.3.1 Problematising 'family medicine' and the doctor-patient relationship

GPs in this study adopted variable approaches to conflict in the family. General practice and family medicine rightly privilege the knowledge a sound and potentially long-term relationship with a family can offer the doctor. The paradigm of family medicine recognises the family as the crucible for the development of the person and family relationships as a critical influence on health and illness. McWhinney explains when 'thinking family', doctors should consider the impact of diagnosis and treatment on the family system (McWhinney 1989). However, while standard Australian family medicine and general practice textbooks urge GPs to 'think family', they do not discuss how intimate partner abuse may make 'thinking family' problematic or in what ways it can cause tensions in the patient/doctor relationship and how these should be managed (McWhinney 1989; Murtagh 1994).

For example, doctors in the study discussed their reluctance to: take sides between partners in a couple; reframe existing male patients said to be abusers; challenge men who abuse in case they left the practice; raise the impact of child witnessing or, (on rare occasions), reportable child abuse with parent-patients. Their reluctance stemmed from concern that it might be detrimental to the adult patient/doctor relationship. With stronger emphasis on the links between domestic violence and child abuse in a family, we should underscore how the important concept of 'thinking family' should be re-conceptualised so that when domestic violence is suspected or confirmed, certain principles of management for both adult and child patients follow. We should consider how the role of the patient/doctor relationship may be problematic in this environment.

7.3.2 Family therapy, couple counselling and general practice

There are further family practice concepts, which may benefit from re-examination in the context of intimate partner abuse. While being urged to remain neutral in the case of 'marital conflict' or any other conflict in the family, in one popular Australian general practice textbook, GPs are also encouraged to be marital or couple counsellors:

> *Family therapy is ideally undertaken by general practitioners, who are in a unique position as providers of continuing care and family care (Murtagh 1994 p9).*

Murtagh advises that 'GPs often have to provide marital counselling for one or both partners' when he is discussing marital disharmony (p.13). In his chapter on counselling skills, Murtagh specifies that domestic violence is a specific area requiring counselling (p.27). In the domestic violence chapter, although most advice is very sound, he does not acknowledge couple counselling as an option nor does he discourage it. The advice he gives is that the perpetrator is generally uncooperative and that 'as a general rule the most effective intervention to stop the violence is to arrest the violent person' (p.769). While some would agree with this advice for many men who are violent, it does not acknowledge that men are diverse, nor that GPs may be tempted to counsel couples, when they do not have the expertise to distinguish couple conflict from partner abuse.

This study suggests that there is confusion among some GPs about the boundaries between marital conflict and partner abuse. Couple counselling can still be taught in a partner abuse context, as the rural project in this study demonstrated. The goal of some GP counselling in this study was family preservation or reconciliation regardless of the severity of the violence, which could have negative consequences for the victim. These findings are echoed in Ferris et al's Canadian family practitioner national survey (Ferris, Norton et al. 1999). Whilst we do not yet know the extent of Australian GP marital counselling of abuse patients, the evidence from Canada and the RACGP VAW project together with this exploratory study, suggest that other Australian GPs may be also offering marital counselling when women are abused. Alternatively, other GPs believed they were able to work positively with couples where the man accepted responsibility for his abuse and both partners wanted to stay together and work for beneficial change. This counselling would be

controversial, but should it be discouraged in all circumstances? What advice should be given to GPs?

This debate about whether to counsel couples at all if there is violence - whether *'conjoint therapy is dangerous, unethical or ineffective'* (Bograd and Mederos 1999) - has not yet been resolved among professional family therapists, especially those in relationship counselling. At the US-based Ackermann (Therapy) Institute, the Gender and Violence Project has been exploring the adequacy of either feminist or psychological perspectives to *'capture the crucial dimensions of abusive relationships'*. Ackermann therapists have focussed on complex contingent counselling which holds onto multiple perspectives, shifting discursive registers, challenging gendered moral schemas about responsibility and *'bringing psychologically informed moral discourses into the therapeutic realm'* (Goldner 1999). This requires a high level of professional expertise.

In contrast, Bograd and her colleagues are more concerned with how therapists can discriminate between couples who can be safely treated and those who can not, what assessment criteria predict lethality and how to conceptualise post-assessment treatment (Bograd and Mederos 1999). These complex questions have not yet been resolved among counselling experts.

A recent Australian Commonwealth family violence project, conducted by staff at Relationships Australia, was funded to examine better practice in integrated family violence services. The authors introduce the section on couples therapy in the final report saying: 'couples therapy is a contentious treatment option for family violence. (Melvin, Muller et al. 1999' p75). After reviewing the arguments on both sides, they conclude the section thus:

> *The effectiveness of couples therapy is still relatively unknown. While studies have been conducted in the area, the research quality has been poor (Tolman and Edleson, 1995). Hamby (1998) states that recidivism rates range from 13 to 100 percent and follow-up is a significant problem. Outcome measures have ranged from reductions in violence to complete cessations of violence which leads to difficulties with comparison' (Melvin, Muller et al. 1999 p79).*

Thus, even for highly skilled therapists, there is uncertainty about the efficacy or advisability of such work. Couple counselling and family therapy may not be attempted when partner abuse has been assessed,even by specialists, without strict conditions around safety, responsibility for change and confidentiality. While many GPs may not be able to distinguish marital conflict from partner violence, it seems wise at this point that almost all current advice to GPs about domestic violence strongly warns against couple counselling (Ferris, Norton et al. 1997). This debate and advice should be incorporated into key general practice texts and general practice education in Australia (McWhinney 1989; Murtagh 1994).

7.3.3 GP counselling and partner abuse patients

Rural GPs in this study prioritised crisis counselling as their greatest learning need . Murtagh argues that more people go to GPs for counselling than any other health-worker (Murtagh 1994). GPs provide non-stigmatised, affordable and accessible primary health care services. In many parts of Australia, the absence of affordable, accessible or appropriate alternative counselling services means that the burden of counselling the distressed, depressed, mentally ill and the abused falls heavily on GPs. Some patient counselling needs relate to the stressors of extra-familial problems such as unemployment, age, gender and poverty (Harris, Silove et al. 1996). Others involve family violence. Some have chronic endogenous mental illnesses. Several patients in this study had all of these.

Australian GPs face many structural and institutional limitations on effective counselling. There is no legislative framework governing counselling in Victoria and no standards or prerequisite qualifications for counselling in general practice (Aged Community and Mental Health Division 1999). GPs work in a fee-for-service system where longer consultations can leave doctors who counsel, financially disadvantaged, as GPs in this study testified. Consequently, GPs may be faced with increasingly complex counselling cases for which they have not been adequately prepared. In the present study, GP counselling ranged from unsafe, unfocussed couple counselling through short term motivational counselling, sometimes irrespective of suitability, to active listening and intuitive empowerment strategies. Many urban and rural respondents felt they required further counselling skills after the training was completed. Many were self-taught and in the country their desire for more counselling expertise was a major motivation for seeking training.

The GPs alluded to problems including:

- Not having sufficient expertise to take a thorough history to elicit either a woman or a man's emotional and practical (eg financial) readiness to change
- Feeling under-confident about their ability to provide longer-term support for women and men who were unready or unwilling to change
- Feeling concerned about how to manage problems such as transference, lethality, safety and case-closure
- Having no evidence base for what counselling works better or best or whether to counsel at all
- Bearing the financial and personal costs of counselling
- Managing the consequent stress and vicarious trauma associated with counselling traumatised people

Family violence counselling casework has been identified in a Victorian government report and the therapeutic literature as a complex and contentious area, requiring great skill (People Care Australia 1997, Goldner, 1999). Counselling partner abuse sufferers requires expertise and

considerable support, as it is demanding and draining even for those who have required competencies. It requires detailed knowledge of a wide range of support agencies such as housing, legal and financial advice.

Many doctors may only wish to offer crisis counselling and referral. However the majority of victims do not present in crisis and while men often do, more often than not, they will not be ready for change. It was clear in this study that rural doctors were more often required to offer longer term counselling of either partner. If we expect any GPs, but especially rural GPs, to provide longer term abuse counselling, we must ensure that they have the expertise. It is beyond the scope of this thesis to recommend how this might be achieved, but it is clear that it is urgently required. There are no published Australian ethical and practice guidelines for counselling individual victims, perpetrators or couples when women are being abused and their development will be welcome.

There are several further dilemmas for doctors in partner abuse counselling from these data, which could be clarified in CME and the published medical literature. First, both current medical philosophy and pro-feminist partner abuse concepts rightly encourage an emphasis on patient autonomy. Whilst autonomy remains a vital principle, many abused women are severely disempowered and feel unable to make changes, are legitimately afraid to do so even to make themselves safe which can leave doctors afraid for them and disempowered themselves that they cannot change the situation. Many GPs in this study spoke of these disabling feelings. The victim-consumer in the rural project warned that this powerlessness could then be mirrored back to the patient and be further disabling. In this study, CME was effective in ameliorating these feelings for GP participants.

Further, the style of counselling required to challenge and enable men to seek to change their abusive behaviour is very different from that of empowering women (Hamberger, Feuerbach et al. 1990). Most Australian doctors would be unaware of a recommended approach with men who abuse or the ethical dilemmas around it, such as the potential for collusion. There is still controversy about the different professional approaches to changing the behaviour of men who abuse, creating considerable debate about outcome research into the effectiveness of men's treatment programs (Goldner 1999). American evaluation found that treatment approaches (ie the style of counselling and other interventions) and length of US male behaviour change groups were unimportant, because all four evaluated projects were quite effective in reducing violent behaviour in many men but completely ineffective in preventing recidivism in about 25%. However, the majority of female partners reported that their lives were improved as a result of the re-education of men (Gondolf 1997). Which men and to whom should GPs refer?

7.3.4 Referral

Referral is the next important step in the case management of partner abuse patients when patients of either sex feel able and willing to make changes. While GPs in the study were motivated to

train in order to learn about referral agencies and were appreciative of the knowledge, many were still not successful in their referrals after the training. Specialist domestic violence workers in this study argued that effective referral was complex and that GPs might require specific expertise to refer and monitor women and men in order to overcome the shame and fear associated with referral. Some doctors in this study suggested that good counselling training allowed them to better assess whether they should refer, rather than immediately passing patients on to new agencies. When male patients are referred to behaviour change groups, evaluation both in Australia and abroad have stressed that it is important to monitor a man's progress with his partner as often accounts differ and men continue to minimise their abusive behaviours (Tolman and Edleson 1995; Frances 1996). We should ensure that GPs are aware of this need.

The Victorian government is currently updating the existing standards for men's behaviour change programs (Younger 1995). All current and any future Victorian men's programs will be funded only if they measure up to the new standards. GP Divisions could liaise with the relevant government departments to ascertain which men's behaviour change programs in their areas are funded and accredited. This would provide GPs with the confidence to refer appropriate and willing male patients to accredited groups.

7.3.5 Debriefing and supervision

A psychiatrist educator in the rural project commented that counselling traumatised patients can cause emotional trauma in GPs, a caution echoed by Warshaw (Warshaw 1997). When asked, twenty-six of the twenty-eight GPs surveyed reported they felt stressed. The rural project clearly identified that GPs were concerned about stress, vicarious trauma and their lack of opportunities to debrief after partner abuse counselling. This study offered some illustration of these stressors and doctors' current strategies to alleviate them. Besides individual strategies however, counselling partner abuse patients is only one area in which GPs may benefit from debriefing, supervision and support, which suggests a more organised approach to the problem overall is required. Partner abuse is only one category where GPs may experience vicarious trauma.

Divisions have the potential, as exemplified in the efforts of the rural division in this study, to initiate and support peer networks of interested doctors and specialists willing to provide telephone advice or supervision and debriefing. Their further initiative to provide regular case discussion groups for difficult abuse cases was also popular with rural doctors as twenty-two made the effort to attend, almost 10% of the division. Some practices ran groups on a clinic basis. These examples could be disseminated nationally. Safeguards for patient and doctor confidentiality should be emphasised.

7.4 Children living with partner abuse

Most of the doctors in this study overlooked opportunities to ask about the safety and the impact of abuse on children. This study has highlighted that one of the critical gaps in GP partner abuse

practice is with the identification and management of children who have either witnessed domestic violence or been abused themselves by either parent. Children's needs appeared to be almost invisible. This serious gap left children vulnerable to more abuse and health damage and in the longer term, GPs missed an opportunity to prevent inter-generational transmission of abuse. Doctors were unaware of the potential for using the impact on children as leverage for change with both women and men, as they were unaware of the strength of the association between child and partner abuse and common symptoms in young people. Consequently, they did not inquire about the impact on children or young people. Some doctors did not report mandatable child abuse or refer children to support services, which might help them with the sequelae of abuse. It is only now that partner abuse services are developing services for children as part of their overall strategy. Until partner abuse services for children are more available and child protection services more effective and trusted by GPs, GPs are less likely to inquire or refer. We need to better inform doctors about the association between partner and child abuse, symptoms of overt abuse or witnessing in children, how to inquire of parents and children about safety and when to report. We should persuade them to inquire about the impact on children in a non-judgmental manner in order to encourage either parent to make positive changes in their lives. Divisions could inform doctors of services in their area to which they can refer children for counselling and support.

7.5 Patterns of partner abuse practice among GPs

Ferris et al identified three profiles among Canadian family doctors distinguishing how they manage the overall problem (Ferris, Norton et al. 1999). The first group of doctors would not do anything regardless of the abuse presented to them. No such doctors participated in this study, as they would be unlikely to seek training for something they would not look for, identify or acknowledge. However, such doctors were obvious in the accounts of abused women in my previous study who, when women disclosed and asked for help, either ignored it or left it to the women 'to sort out' themselves (Taft 1995).

The second group would take some action only if women acknowledged that there was abuse. Such action could range from offering information to actively planning for her safety. The third group would take some action whether the woman acknowledged abuse or not. Such action could include sensitively offering information and support to women who are not ready to disclose, but in whom the doctor suspects abuse. By contrast, some doctors talk with the abuser about stress or the relationship. The latter action, Ferris et al found, could occur regardless of the quality of the doctor's relationship with the male partner. The authors express concern about these actions and others, such as couple counselling (Ferris, Norton et al. 1999).

Doctors in the present study only discussed their management with women who had disclosed. They did not report those in whom they only had suspicion until they confirmed that suspicion after training, but no one reported taking any action, helpful or otherwise, without disclosure. There were however, instances of doctors in the study who spoke with men who abused if they

knew them, regardless of whether they had good relationships with them or not. Some attempted couple counselling on the same basis. Speaking with the abuser without the competency to do so effectively, can endanger both the patient and the doctor. Doing so without the victim's permission can also endanger her and examples of this were given in two cases anecdotally. Unhelpful management was evident in some examples of victim-blaming, collusion with the man who abused, inappropriate medication of victims and perpetrators, advising women to leave whether they were ready or not and frustration with the non-compliance of victims. Similarly, some doctors overlooked or minimised abuse or used ineffective or unsafe couple counselling. In this study, such management strategies occurred more frequently among the male doctors.

Other doctors practised empowerment counselling with female victims intuitively and training affirmed this practice. They gained confidence and additional resources, both printed and in-person links with community based referral agencies, to which they could turn for advice and to which they could refer. In this study, more of these doctors were female. McWhinney acknowledges that communicative distance exists between cultures, but that gender, class and medicine are also cultures which can distance and therefore require communicative sensitivity (McWhinney 1989). Of these three cultures, the greatest influence in this study related to gender.

7.5.1 Gendered practice

This study addressed the question: Does the GP's gender have any role in effectiveness and if it does, how can that understanding inform improved training and better practice? The detail from the study narratives did illustrate ways in which gender appeared to impact on practice in a small sample of doctors. Proportionally, many more female GP participants than male in this study sought training about partner abuse, as they have done nationally (Royal Australian College of General Practitioners 1994). This may reflect the greater numbers of partner abuse patients presenting to them.

As the gendered organisation of medicine is challenged by feminisation, subtle changes have been observed (Britt, Bhasale et al. 1996). GPs have been described as the 'subalterns' of medical practice, which makes it unsurprising that both in Australia and overseas, there are more women becoming general practitioners than the more prestigious specialists. However, scientific medicine has been challenged and the medical capital invested in biomedicine has diminished. With rising rates of depression and subsequent need for counselling, women's gendered empathic qualities have become a valued form of medical cultural capital (Pringle 1998). It is not surprising that researchers have detected gendered medical practices, with more female doctors than male seeing psychosocial cases. (Britt, Bhasale et al. 1996; Chambers and Campbell 1996). If this is the case, it is likely female doctors will see more domestic violence cases, as the female GPs in this study reported. Many female victims believe that female GPs will treat them more sympathetically and that male doctors will side with their partners. Some do not trust any males as men have abused

them (Taft 1995; Head and Taft 1995). If a woman's usual doctor is female, Hegarty found that she is more likely to disclose to her than if her usual doctor is male (Hegarty 1998).

Domestic violence is a deeply gendered issue. There are many plausible explanations for gender playing a significant role in domestic violence medical practice. Doctors in this study believed that gender played a role in their practice with partner abuse patients, although they varied in their views about the manner in which it did so. Some male doctors expressed the view that men would be more likely to disclose to them and women less likely, because they were male. Others differed and believed that smaller numbers of women and men would disclose to them, as both sexes would prefer to discuss emotional problems with female doctors. This is consistent with gendered patterns of family expectations where women are socialised to do the emotional work. Doctors in this study were conscious of patients' possible gender preferences, with more male than female doctors saying that their sex/gender prevented their asking women about their private lives, particularly those culturally distant from their own. Some NESB male doctors felt a stronger sanction against asking women about intimate matters.

Most doctors who sought training were empathic, but the female doctors identified with victims and even without training, were less inclined than the male doctors to blame women for provoking the violence. They were more likely than the male to express tolerant attitudes to women who did not leave abusive men. More male GPs than female expressed understanding of why men might abuse, sought family reconciliation or cohesion and came close to colluding with men, through medicating the women or expressing patriarchal attitudes about difficult partners. This is a tentative observation, as this is a small sample.

Researchers have not reached agreement about whether male and female GPs practise differently when dealing with abuse patients (Saunders and Phillips Kindy Jr 1993; Rodriguez, Bauer et al. 1999). The many similarities are more apparent than any differences. However, with intimate partner abuse, the gender differences between patients and doctors can be sensitive and may influence how women and men fear they could be perceived should they disclose and indeed may influence how untrained doctors might treat patients disclosing to them. Doctors' gendered dispositions and practice were not always consistent and could be modified by other parts of a doctor's habitus through religious, ethnic or medical enculturation. Nevertheless, gendered attitudes were present in this study and in good practice, doctors would be mindful of dispositions which they may not only bring into the consultation, but which affect their consequent management decisions.

7.6 Reflexivity - towards more mindful practice

Studies have found that doctors place more responsibility for patients' non-disclosure on patient difficulties than any impediments they might bring into the consultation (Sugg and Inui 1992; Rodriguez, Bauer et al. 1999). This tendency was the same in survey and patient narratives in this

study in both disclosure and management practice. In a clear example, Dr Errol Threadgold, pressured by the time demands of his practice and frustrated with his inability to bring about changes in Andrea, blamed her for the lack any progress in his work with the couple. He seemed unaware of the impact of his own attitudes in his practice.

Additionally, many GPs' descriptions of counselling suggested the concept of a 'sounding board'. This metaphor of the 'sounding board' (and some GP accounts of their consultations) implied that doctors could perceive themselves as neutral mirrors in which patients are able to see themselves truthfully reflected, rather than as active and present participants in a dialogue. They did not indicate awareness of the impact of their own attitudes and values on the patient and the outcome of the consultation. Epstein proposes a strategy for critically self-aware medical good practice he calls mindfulness:

> *Exemplary physicians seem to have a capacity for critical self-reflection that pervades all aspects of practice, including being present with the patient...and defining their own values. This process of critical self-reflection depends on the presence of mindfulness. A mindful practitioner attends in a non-judgmental way, to his or her own physical or mental processes during ordinary everyday tasks to act with clarity and insight (Epstein 1999).*

If doctors were trained to cultivate the critical self-reflection Epstein recommends, they would be insightful about the potential impact their individual presence and actions in the consultation could have on their domestic violence practice. Such insight could assist doctors to develop a flexibility of management practice as suggested in the RACGP WAV project (Royal Australian College of General Practitioners 1994), sensitive not only to the nuanced forms of abuse presented by diverse patients but also the contingencies necessitated by their unique professional persona. Mindfulness is a critical addition to the repertoire of skills a doctor requires to work effectively with intimate partner abuse and the many other psychosocial aspects of medical practice.

7.7 The GP clinic and intimate partner abuse

In addition to the individual GPs' need for further expertise in identification and management skills in partner abuse and in mindfulness, there are broader management skills identified from this study arising from the needs of victimised patients, involving the administration of GP clinics.

7.7.1 Coordination in the clinic

If victims in the study attended a group practice, they could see any one of a number of doctors. In several practices in this study there was no time or protocol organised so that doctors could alert each other to the need to be vigilant to any change, eg in thresholds of danger (such as increasing threats), in the opportunity for beneficial change or the need for support. Often the abuse was noted in the files, but no clinic had a protocol to notify colleagues of the existence or suspicion of abuse or warning signs, such as suspicious bruising or injury. This is advisable so that all doctors

who might see the woman or her partner were alert to her predicament. More than this, each colleague then understands what to do in any change of circumstances.

Similarly, when couples attended a particular practice, each partner could see different doctors. In some cases, in order to preserve the doctor-patient relationship, doctors referred the partner with whom they were not as comfortable to another colleague in the practice. However, without a protocol to ensure that some within-clinic case management was implemented, neither doctor could be sure of the other's current concerns, including whether there was any change in the victim's safety status or opportunities for intervention. In one case (Mrs Davis, Appendix 1, No 2.1), a junior doctor felt unsupported by her colleague and frustrated with her discomfort trying to catch him for a 'corridor chat' or to raise the issue in any informal get-together. She felt her ability to make a clinical judgment about the case consequently weakened.

Even with coordination between doctors managing a couple, the needs of children provided a challenge to good family case management in either group or solo practice. Adult patients may often take precedence when all family members attend the same practice. It requires mindful practice for a doctor to ensure that a parent's needs do not block their consciousness of any children's needs. It is important to check that someone advocates for the children's needs. The most extreme example of this can occur when the woman separates from a violent partner, as not only the woman, but also her children may be at grave risk of homicide.

7.7.2 Staffing and safety issues

Some doctors, such as Dr John Forrest in Chapter Six, were very uncomfortable with direct inquiry, others much more comfortable. Given the different degrees of comfort doctors expressed about domestic violence, the development of multi-disciplinary group practices offers less confident doctors further opportunities for delegation of tasks. Such staff can range from nurse practitioners, who could screen female patients for abuse in solo male practices, to counsellors and psychologists (more common in UK general practice). As in the UK, there is the potential for counsellors or psychologists to undertake the counselling for which GPs do not have additional expertise. However, the current Australian GP funding system does not easily support the development of multi-disciplinary clinics, as nurses and psychologists do not have access to Medicare rebates and must be funded directly from clinic income or staff practise privately.

Some doctors, such as Rural male 6 and Dr Peter Greenway had female patients with partners who were very violent and in some cases, frightening. Not only doctors, but also other staff can be at risk if a victim flees into refuge and a violent partner is looking for her. This possibility may become more likely as doctors become more adept at managing victims effectively and safety protocols with local police may become more necessary.

Urban doctors were very concerned with improving their communication and support for NESB patients. Employing bilingual staff is one important method for general practices in culturally diverse communities to deal more effectively with patients from those communities.

7.7.3 Working in multicultural communities

There was great cultural and linguistic diversity in both GPs and their practice populations in the urban division. However, the experience of female patient victimisation or male patients using abusive behaviour appeared to have more similarities than cultural difference from other patients. Doctors reported patterns of controlling male behaviour or intermittent physical abuse and female victimisation and consequent health damage in their patients across all the culturally and linguistically diverse communities with whom they dealt. In almost all cases, doctors' problems related to a lack of confidence and expertise overall. A few NESB GPs expressed concern at cultural sanctions against inquiry about private relationship issues, in the same way Australian police and other services were wont to express, until professional attitudes and standards altered when they were given more expertise.

GPs are accessible primary health care services for victimised women, whatever their culture. NESB patients are at greater risk than other patients as they are less likely to know their rights or how to access early intervention support services. This strengthens the importance of general practice as a critical setting for supportive intervention with NESB patients who need help with partner abuse. My previous small study of victimised women's experiences found no cultural differences among women about what they wanted most of GPs (Taft 1995). There is no population level research about victimised NESB women's views, but research in other areas sheds some light on women's preferences in health care settings.

Small et al explored the views of a large sample of Vietnamese, Turkish and Filipino women about their maternity care in Victorian hospitals and shared care services (Small, Liamputtong Rice et al. 1999). They concluded that:

> *What the women...most wanted from their caregivers was something much more basic and universal than attention to the specifics of cultural practices...Rather than implementing strategies which focus attention on cultural variations in ...practices, attention to the quality of care women receive and addressing more thoughtfully the barriers to effective communication brought about by language problems.*

This, they argued, would be likely to lead to real improvements in the care women receive. They cite other studies, which have found similar results.

It is likely that the same management principles apply in the field of GP partner abuse practice in diverse communities. Sensitive, kindly and empathetic inquiry about women's actual experiences and preferences, rather than assuming cultural conformity is likely to be received with gratitude by NESB women. Similarly, empathic and concerned inquiry about male patients' practices and experiences may be similarly received. Doctors' competent counselling, sensitivity to language

barriers and mindful practice would ensure the communication of important information about options. Effective take-up of those options would depend on the same expertise.

Some urban case doctors employed further useful general strategies, which enhanced their partner abuse practice. Dr Jill McPherson attended functions at ethnic women's agencies in her area and was well acquainted with their services. She was skilled at working with interpreter services and knew the ethnic social workers. She accepted community interpreters if patients insisted. Such cross-fertilisation meant that there were many referrals both ways between the clinic and the agencies and Dr McPherson understood the cultural context and the limits by which both her male and female patients were constrained. She also made herself familiar with immigration, education and employment issues for her migrant and refugee patients.

Dr Errol Threadgold attended cross-cultural workshops and his practice employed bilingual allied health workers and administrative staff. Consequently the practice had many patients from the communities, from which staff originated, which can be advantageous, but also has its hazards. Culturally diverse patients will generally be more comfortable with practices, which employ staff from their communities, but occasionally victims may feel more reticent about disclosure in case the staff find out. Therefore doctors need to assure patients that their practice is confidential.

Doctors can learn from interacting with their patients, with multilingual, multicultural staff, ethnic support workers and ethnic community agencies. They can ensure they are well informed about structural constraints on patients' lives. Divisions are increasingly taking a role in reaching out into their culturally diverse communities to welcome support agencies into collaborative relationships. Such collaboration could be extended if divisions are to support GPs to deal effectively with partner abuse.

7.8 From collaboration to integration? General practice in the family violence/primary care system

Lack of knowledge and familiarity with other workers in the domestic violence service system contributed to the anxiety and diminished the confidence of many doctors in this study. To their credit, this motivated many to seek training. Furthermore, doctors were very unsure about their role within the wider family violence system of police, refuges, domestic violence outreach workers, men's groups, legal and counselling services and child protection. Should they manage the overall coordination of cases, were they a 'first port of call' or one player in a potentially co-ordinated system, managed by others? Several doctors expressed fears about losing patients if they referred to specific services, others reported a lack of trust in the services (particularly child protection) or frustration with the paucity of feedback. Most of the concerns reflect an unfamiliarity and lack of communication with specific agencies, but also the need for more conceptual clarity about roles and responsibilities between services providing care for victims and other family members.

Divisions offer the potential for GPs to develop coordination at an organisational level with wider family violence services. Through their collaboration with abuse agencies in this training, the divisional CME projects demonstrated the potential for collaboration between divisions and the wider service system. The fact that other providers, such as police, family and domestic violence service providers outnumbered GPs two to one in the rural network sessions indicated the importance which service providers attached to networking with GPs. GPs were very positive about the value of the networking sessions. Some had begun to consult police and domestic violence colleagues when they were unsure of their management direction. It strengthened both their confidence and their practice. This was one important step towards a more collaborative system.

However, within the health care system, many distinctions between GPs and other providers can make collaboration difficult. GPs in this study were fearful of losing 'their' patients and frustrated with poor communication and feedback from referral agencies, similar to the findings of Powell Davies et al (1996) In addition they discussed GP organisational and funding structures - that GPs are private businesses, funded largely on a fee-for-service basis by federal Medicare funds with uncapped funding, now loosely organised into divisional structures (Powell Davies, Harris et al. 1996). However, most other providers in the family violence service system, whether community health centres, community legal services, domestic violence services or the police are otherwise funded and organised. This, together with other problems, can create some difficulties for collaboration and coordination between individual, agency and at a larger organisational level. Until very recently GPs were not funded to spend time away from direct patient care to participate in case management or coordinated care. However, changes to the Medicare schedule have enabled GPs to be paid for coordination time, although these appear to be limited to medical conditions found in the elderly and chronically ill. These funds could be allocated to abuse case coordination.

Whilst coordination occurs when agencies take specific steps to ensure their activities fit in with each other, but do not operate as a combined system, integration occurs when separate agencies are drawn together into a larger whole. Within primary care, there is no over-arching policy providing a framework for service integration, and this absence, together with competitive tendering, can encourage competition between agencies (Powell Davies, Harris et al. 1996). Similarly, there is no agreed policy framework clarifying the role of GPs with other providers within the family violence system and a certain amount of suspicion and competition between GPs and other abuse agencies was observed during this study. Policy development and clarification of roles and responsibilities, the development of joint protocols and other mechanisms of coordination would greatly assist general practice effectiveness in dealing with domestic violence. Dialogue and consultation towards a jointly agreed policy framework would be a government responsibility at state or federal level. It would also provide clarity for the education of GPs about their role in effective early intervention.

7.9 Towards an integrated GP curriculum for CME and partner abuse

In the preceding pages, I have argued that in general, GP education about intimate partner abuse to date has not recognised the full range of affected patients (ie victims, abusers and their children) whom GPs see. While the CME training explored in the two divisional projects outlined here expanded the pioneering RACGP Violence Against Women program (by including work on men, children, crisis counselling and vicarious trauma) I contend that further development is still required. Some areas still to be included in medical education are: theoretical integration with family medicine, distinguishing marital conflict from partner abuse, counselling competencies with women, men and children, mindfulness with a focus on attitudinal change, case management and coordination and understanding the wider social context of partner abuse.

7.9.1 An integrated approach to medical education in intimate partner abuse

The success of CME training depends to an extent on the foundations on which it builds. To date in Australia, undergraduate education about domestic violence has been ad hoc and vocational education about partner abuse, voluntary. CME attracts those GPs interested in improving their expertise in an area of relevance to their work. Therefore many GPs have had no exposure to partner abuse at any level of education, as they do not identify it. There has not yet been any attempt to integrate a partner abuse curriculum from undergraduate through vocational training into CME to strengthen GP expertise in the management of family violence. Consequently the cases in this study illustrate the misunderstanding, which can emerge between GP vocational and CME training. CME training is attempting to challenge earlier professional development and will encounter resistance.

There are promising developments in the new Australian postgraduate core curriculum revised by the RACGP Training Program in 1999 (RACGP Training Program 1999a). This curriculum incorporates many important general features of good practice in partner abuse management: reflective and critical consciousness; ethical practice; involving community agencies in teaching; the implications of cultural diversity; masculinity and violence; the role of abuse on women, men and children. It is unclear how these will be integrated in the curriculum content area on domestic violence and who will teach them. However, it does suggest that the future accredited GPs entering the GP workforce will have a better portfolio of existing competencies on which future partner abuse CME can build. I outline below the implications for CME training of the findings in this study.

7.9.2 A model CME program for partner abuse

Since the advent of divisions, drug companies, universities, hospitals, community agencies and divisions themselves have increased the flurry of CME constantly competing for GPs' attention. Within this hubbub, many agencies, women's services, community health centres, domestic

violence services and others have sought to train GPs about domestic violence. Consequently a plethora of training projects has developed, many reinventing the wheel or parts of it and with differently defined competency goals (Schweitzer 1995; Domestic Violence and Incest Resource Centre 1999).

In 1993, a federal government review of family violence training recommended a core curriculum and a specialist training (train-the-trainer) unit with defined core competencies to provide domestic violence training to GPs (Tomaszewski and Ollie 1993). Regretfully, this remains only a partially fulfilled recommendation. An updated curriculum could be delivered by such a specialist-training agency in collaboration with divisions and local support agencies. The RACGP Women and Violence Unit fulfils some of this role and their curriculum provides a valuable foundation which could be further developed with the addition of specific competencies. Other elements, such as those outlined above, could be integrated into the curriculum and competencies developed in relation to new federal government domestic violence core competencies (Mulhall 2000).

In addition to knowledge and skills in such a core curriculum, training should provide an environment in which doctors could confront the feelings and social beliefs that shape their responses to patients. They should be offered new frameworks for understanding complex social issues and collaborative models for working in partnership with community groups (Warshaw 1997). The training must be sustained. Essential to this project are the skills, knowledge and insight of the teachers and the strength of their teaching methods.

7.9.3 Trainers and training methods

The two projects demonstrated that the skills and attitudes of teachers are essential to the success of the learning. There is a need for trainers to be able to sensitively and insightfully challenge trainees' uninformed attitudes, both teach and model appropriate ones and be skilled in group facilitation. In these training projects, most trainers were not skilled educators and did not have opportunities to consider how their teaching objectives and methods fitted into the overall curriculum. Only one educator was skilled in challenging attitudes and he was successful in doing so. The proposed federal training unit would require both female and male teachers with this expertise. Additional funding is required for the development of further resources to those already made available by the RACGP WAV training project.

One of the great strengths of the two projects reviewed in this study was the integration of consumer testimony with teaching, also valued in US undergraduate teaching (Ambuel 1996). The use of women who have survived different forms of violence and men who formerly used violence but have stopped as consumer-consultants, was greatly valued by GP respondents and should be encouraged in CME training. Using a variety of (preferably paid) consumer-consultants discourages the stereotypical perception that there is only one type of victim or abuser and the complexity of types must be emphasised if only one consumer-consultant is available. If consumer-consultants are willing, their involvement would be preferable in role-plays to the use of

pairs of doctors as they can offer more constructive insights and feedback. Alternatively, standardised patients have also been valued in medical undergraduate partner abuse training (Short, David et al. 1997). The use of consultants and standardised patients would be valuable in competency assessment.

GPs in this study reported strong and consistent preferences for opportunities to bring their own experience and practice dilemmas, to consider case studies and to discuss options for management strategies. They preferred small group discussions and feedback from teachers with expertise. That person did not have to be a doctor, but someone with partner abuse expertise, who understood the demands of general practice. These requirements could be met by collaborative teaching between GPs and domestic violence experts. There was no use made of collaborative teaching by GPs and domestic violence workers in the training projects described in this study. Joint training offered by GPs and community workers together is a model for collaboration. Warshaw recommends an advocacy model in teaching and a core curriculum developed by both GP trainers and domestic violence expert offers a sound method to develop such a model (Warshaw 1997).

The rural networking sessions were a further valuable training method from these innovative projects. GP case presentations and agency responses in the meetings proved an excellent way for community service providers to introduce themselves and their agencies, and for GPs to learn about both. It also allowed the community agencies to meet GPs. GPs learned what resources would assist with certain problematic cases. Many GP respondents were keen to continue such meetings at regular intervals. The development of coordination between divisions and the agencies in the region would enable regular and sustained networking. If such coordination occurs, a training agency could negotiate more easily with the relevant agencies for regional adaptation of the core curriculum.

The evaluation of these projects was methodologically and financially limited, which is similar to much CME evaluation. The major limitations related to those associated with self-reporting and the projects' ability to test the acquisition and use of newly acquired skills. The use of standardised patients and trained consumer-consultants offers further opportunities to evaluate whether GPs are practising in appropriate and competent ways. Other strategies, such as peer review and practice accreditation offer alternative methods. Evaluation should be undertaken soon after the training and again after a longer period to see whether newly acquired understandings and skills are sustained. Most importantly, as Haynes reminds us, we need to assess its impact on patient outcomes (Haynes, Davis et al. 1984). A randomised intervention trial of the new curriculum is required which would include the impact on female, male and young GP patients who live with partner abuse.

7.10 Core components of a GP CME intimate partner abuse curriculum

I proposed above that the results of this thesis suggest many further components could be added to the curricula trialed in the two innovative CME projects profiled in this study. Accordingly, I outline below the proposed core components of an integrated curriculum, which include these suggestions. I recommend they are further developed, tested, implemented by a new national family violence health services training body and evaluated in a randomised intervention trial.

1. Family medicine, intimate partner abuse and other forms of abuse in families. This unit would develop a theoretical understanding uniting concepts from family medicine with other social theories of gender, power and abuse and draw these out into the realities of general practice. The Heise ecological model could provide a visual schema from the individual out into society (Heise, Ellsberg et al. 1999).

2. What is intimate partner abuse? How can we distinguish it from other forms of conflict in intimate relationships? Who suffers and who uses abusive behaviour? The unit would explore the continuum and complexities of abuse, its likely prevalence in general practice and the diversity of those who might present to GPs. This unit will also stress the presence of, and impact on, children.

3. Contextual factors which mediate patients' experiences (both those who use and those who suffer) of abuse and shape their options, including homosexuality, ethnicity, immigration, religion, socio-economic status etc.

4. Individual and systemic factors which shape providers' responses – the importance and the skills of mindful practice. This unit would provide safe and comfortable ways in which GPs could consider the personal experiences shaping the practitioner whom patients meet in the consultation. It should provide practical exercises and constructive critical feedback.

5. Inquiry and disclosure – the GP's role. How adult and child patients may present. Learning the different skill required to challenge minimisation with the abuser and acknowledge the victim's decisions about disclosure. Inquiring about children and young people. Defining the limits to the doctors' responsibilities and what can be considered good practice in inquiry.

6. Counselling intimate partner abuse. This unit teaches GPs a range of flexible counselling options and how to make clinical decisions about one's expertise in the area. The dangers of couple counselling, stages of readiness to change and when to intervene, counselling from denial to crisis, learning your limits and when to refer. The importance of monitoring the patient's progress and the safety index. How to manage goal-setting, closure, transference and vicarious trauma would be included. Opportunities for debriefing and when supervision may be required would be discussed.

7. Managing partner abuse. Safety first, assessing safety and lethality and the importance of a safety plan. Taking a comprehensive history, including financial, housing and employment status etc and the impact on children. The importance of non-judgmental stances, affirmation, support and hope for both victims and perpetrators, monitoring change. Information and referral options and ethical issues in practice. Managing children.

8. The referral process in partner abuse and the GPs role in the family violence system. This topic should be taught as a networking and collaborative project with relevant community agencies and focus on enabling strategies.

9. Case management in intimate partner abuse. Documentation and file management, legal issues, staffing and safety issues, coordination within the clinic, the advantages of multi-disciplinary practice and inter-agency coordination are all included.

10. Bringing about community wide change. How might the individual practitioner who wishes to, forge alliances to bring about beneficial changes to reduce partner abuse in the wider community? An optional unit.

7.11 Summary of further necessary research in general practice and partner abuse

Throughout this discussion, I have alluded to research which remains to be conducted in order to inform the medical education of practising general practitioners who wish to help their patients living with partner abuse. The following list briefly draws these recommendations together.

- Population level studies of the characteristics, health problems and health behaviours of men who abuse in the general community and those who are patients in general practice
- National random survey of current GP management practices with women, men and children living in families where partners are abused
- GP management intervention studies with victimised women
- GP management interventions studies with men who abuse
- Inquiry and management intervention studies with children and young people who live in families where there is intimate partner abuse
- The development of standards and accreditation of forms of counselling in general practice
- Counselling competency development for counselling different types of victimised women and man who abuse

Finally, this study has explored in depth the ways in which some Victorian general practitioners responded to the partner abuse among their adult female, adult male and child patients. It has focussed attention on the fact that all these family members seek and require help from doctors. It has explored what further capability GPs and other stakeholders believe family doctors need and

proposed the framework for an extended curriculum in partner abuse training, which responds to these needs and how this might be implemented and evaluated.

In the title of this thesis and the introduction on page eleven, I suggested that 'lifting the lid on Pandora's Box' was an appropriate metaphor for this thesis and that the myth of Pandora was symbolically rich for the study. When doctors express their fear at 'lifting the lid' and revealing the pain, misery and violence within the Pandora's Box that is intimate partner abuse, when they recoil from being overwhelmed by their patients' misery and their own at being unable to change it, they too, can blame Pandora for the whole catastrophe. What effective partner abuse training can do, is not only offer doctors the skills to perceive Pandora less judgmentally and manage Pandora and her family, but to understand that they themselves are the bearers of hope for all their abused and abusing patients and that hope is what they offer when they confidently and competently 'lift the lid'.

This thesis aims to assist those GPs who wish to practise more effectively with their patients who live with partner abuse. It originates in the wishes of those women whose doctors transformed their lives, for other women like them to have their lives similarly transformed. Therefore, the last words in this thesis are left to women from my earlier study about those wonderful GPs who had the qualities and understandings to help them:

> *My husband attended a GP looking for anti-depressants because he wanted the quick answer, he was used to taking drugs and stuff like that...and he said I'm not giving you any pills and referred him here. He said the problem you've got needs to be dealt with counselling and you need to deal with why you're feeling that way, rather than having pills, which was really good.*
>
> *I had everything organised so that at one stage I could have walked out of that place and have a house and money straight away to live on and it was only because of her. Up until that stage I didn't know about any of those things. She gave me options of what to do with my child, whether we wanted to charge his dad... I felt I could trust her, because I knew that whatever I told her wouldn't go any further.*
>
> *Once a month we'd [separated female patient and her sons] front up to the court house and we'd go to Dr M beforehand and say we're off again. And he'd - say remember the meditation, remember this, remember that, this might help you. And he was great, really wonderful. There should be about 15 million more doctors like him.*

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APPENDIX A: CONSENT FORM

Consulting GPs about domestic violence training

PhD Study ANGELA TAFT
National Centre for Epidemiology and Population Health
Australian National University
Canberra

Thank you for your participation.

I consent to be interviewed Yes ☐ No ☐

I give my consent to Angela Taft using a tape recorder Yes ☐ No ☐

I wish the transcripts to be sent to me Yes ☐ No ☐

I consent to the tapes being stored then destroyed after two years Yes ☐ No ☐
(if no, then I expect that they will be erased immediately)

Please send the transcript and/or the summary to this address

_____

_____ Signature

_____ Date

APPENDIX B: LETTER TO GPS

Angela Taft

(03) 9819 5350 ph

(03) 9818 7497 fax

ataft@deakin.edu.au

CONSULTING GPs:

PERSPECTIVES ON GENERAL PRACTICE CONTINUING MEDICAL EDUCATION ABOUT DOMESTIC VIOLENCE.

Dear Doctor,

My name is Angela Taft and I am a full-time (mature age) Ph.D scholar at the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University. I am conducting a study of GP continuing medical education in domestic violence. The purpose of the study is to support the further development of effective GP domestic violence training. I am conducting the study in collaboration with both 'Rural' and 'Urban' divisions of general practice. I will be seeking the perspectives of other stake-holders, but the major focus is the views of GPs.

As indicated in the letter from divisional project staff, I am planning to phone you to invite your participation in the study. This would involve arranging an interview with you at a time convenient to you. In addition, I would appreciate your consent to my observation of the training forums in the division. No individual will be identified and the division's representative on the study's reference group will check the draft report to ensure your interests are protected.

Continuing Medical Education around this complex issue is in a developmental stage both in Australia and overseas and your contribution to the further development of training would be invaluable. I hope to work with you,

yours sincerely

Angela Taft

APPENDIX C: PRE AND POST-TRAINING QUESTIONS

PRE-TRAINING QUESTIONS

Age?

Full or part-time?

Vocational Registration?

What motivated you to undertake this training?

What do you think is the prevalence of domestic violence in your practice population?

What kind of violence is that?

How many (female/male) victims of domestic violence would you see in a month/three months/year (if too short)?

What do you do if you suspect domestic violence?

How do you currently manage cases of domestic violence when you encounter them?

What would you like to learn?

What are your preferred methods of learning about these and similar issues?

What do you require of the teachers?

What, if any, are the advantages or disadvantages of being a female/male GP in these circumstances?

Why do you think more of your fellow GPs haven't volunteered to be trained?

POST-TRAINING QUESTIONS

Rural division	Urban division
How well did the flexibility of the format, evening upskilling meetings (and lunchtime networking) suit your needs? Which upskilling workshops did you attend? (check each one) What was your opinion of these? Did you attend the local networking session? How helpful did you find that?	How well did the format (two by two hour session) suit your needs? Explore. What was your opinion of the first session on victims? The second session on perpetrators?
Did any of these sessions surprise you or challenge your thinking?	
You commented that you would like xxx to teach you. Can you comment about which presenters were most/least effective? Probe/explore eg use of consumers	
In our first interview you told me you wanted to learn xxx, how well did the sessions you attended achieve this for you?	
How confident are you now about dealing with domestic violence? Could anything more have been provided that would have helped you more? Gaps in training?	
What skills do you believe you have strengthened? Have you changed or do you plan to change your management of abused or abusing patients? Can you tell me how?	
Can you tell me about any new victims or abusers you have identified since the training? Probe.	
How effective was the training in helping you to identify and manage children living with violence?	
Many GPs have said that there are times when they are not able or prefer not to refer victims of abusers for counselling. Is that the case for you? How did the training help you to manage any problems involved in such counselling?	
How if at all, has the training helped you to deal with stress? Who, if anyone, should provide support for GPs to deal with work-related stress?	
Have you learnt about any new referral agencies through the training. Can you tell me about any new ones you've used? How useful were they?	
Have you used any of the resources (remind) the project provided? How useful were they? (If appropriate) Have you had any feedback from patients about the resources?	
Some doctors say that CME can be quickly forgotten. How could this learning best be consolidated for GPs?	
Were there any unexpected outcomes, either positive or negative, of the project?	

APPENDIX 1

GP PATIENT NARRATIVES

Overall, there are forty-nine patient narratives in the full transcripts of case doctors' interviews. However, six further cases in the pre-training interviews were so rich, I have included them. Some are women and men who appear only once, others appear intermittently and some regularly. Of the fifty-five stories, the majority concerned female patients. In providing summary case narratives for the readers of this thesis, I have chosen those three from each doctor which best illustrate common themes and concerns. My major purpose in this section is to allow the reader to judge how doctors conceptualise patients. These stories illustrate the complexity of the intimate partner abuse and other forms of family violence with which doctors are confronted.

All doctors' and all patients' names and any clearly identifying details are fictitious to ensure their anonymity.

The rural doctors:

1. Dr Peter Greenway and his patients

Dr Peter Greenway is an Anglo-Australian rural male GP in his mid 50s. For the last ten years he has practised medicine with his GP wife in their family practice in a small country town. They own another practice in a small nearby town. Dr Greenway is committed to his town community, involved in community charitable organisations and enthusiastic about his practice. He is very interested, whilst largely self-taught, in counselling and devotes at least one evening a week to providing motivational counselling for patients with psychosocial problems. The practice also employs nurse practitioners, paid for from the practice budget. Dr Greenway teaches on the RACGP training program, where he highlights abuse issues, as he has successfully managed some longstanding hidden incest survivors whose stories had never previously been disclosed and whose consequent health problems had been great burdens until disclosure.

1.1 Dr Peter Greenway, Amanda and her family

In our first case interview, Dr Greenway introduced Amanda and her family, whom he had known socially. He introduced them as a family where *funnily*, Amanda appeared to be the more violent partner. She is one of Dr Greenway's two major success stories, and was a moving consumer consultant to the training project. When he first introduced the family, however, they were:

> *'A family where there was a fair bit of domestic violence going on between mum and dad, and mum was alcoholic and there was a lot of fighting going on. Not just dad against mum, in fact mum used to get very drunk and hit people and thrash around, and the two teenage boys, or at that stage they would have been about eight and ten in fact, appeared to be undamaged by the whole thing. It was like it was just happening on another planet.'*

At times, called by either parent or the neighbours, when it was *'pretty ghastly'*, he had taken the boys out of the violent environment. Amanda had attended Dr Greenway for sexual dysfunction and complaints *'too numerous to mention! Painful periods, tummy aches, headaches, migraine, neck aches, shoulder aches, you name it she had it'*. Her husband attended for terrible psoriasis and the boys with asthma. Dr Greenway finally asked her about her childhood.

'The actual problem with mum was that she had an extreme childhood sexual abuse history'.

Dr Greenway described how over three sessions, the full story of Amanda's trauma of repeated vaginal and anal childhood rape by her father had taken place. He described how he perceived she had responded to it:

> *'It's like this sort of hideous gargoyle in your memory and as soon as you glimpse it you look the other way because it's just too hideous to contemplate'*

Dr Greenway was disillusioned by previous referrals to CASAs, which he believed retained women in victim mode. He decided on another course of action related to his belief that in the country, family members will always need to relate to each other at family gatherings, which will inevitably take place.

> *'I taught her just to face the gargoyle, just to face what had happened in her life, and just to come to peace with that however much she ran away, this memory was in her head, she just had to, you know, she either ran away from it or came to peace with it.*
>
> *Q: Was that your prime goal? You said you had negotiated goals with her...*
>
> *My prime goal with her was that she forgave her father. And that was a very, very confrontational goal for her.'*

Following several counselling sessions, Dr Greenway reflected how he believed she had progressed and the impact on the family:

> *'In the last 18 months, since asking her, there's not been one fracas at the house...She just doesn't need to be in the surgery any more. She goes off and she plays mid week ladies tennis, and she's involved with the local church group and she's back into what would be considered an extremely normal middle class existence.'*

Amanda was estranged from her mother, while now reconciled apparently well with her father, who has apologised to her and her sister, whom he also abused. Her mother did not want the whole thing dragged into the open *'raking up mud from the past better left buried'*. Her older son was arrested for a minor offence, but since being referred to a psychologist has improved his schoolwork and ceased offending. Dr Greenway says the whole family have benefited from Amanda giving up abusing alcohol, smoking and causing fracases.

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1.2. Dr Peter Greenway, Sophia and her father

In our **second** interview in October 97, Dr Greenway told me about seeing an Italian teenage girl, Sophia, who presented with vague abdominal pains and headaches. When tests failed to uncover anything, he asked about her childhood:

> *'And in fact there had been a history of mild, in a physical sense, physical abuse, by ... on one occasion by her grandfather, and on one occasion by her father's best friend.*
>
> *Q: And what's mild?*
>
> *A single occasion of touching genitalia'.*

She then revealed that when she and her mother (who had believed her) had told her father, he called her '*a filthy little liar and if she said things like that again, he'd break her arm*'. Subsequently, the parents separated. Sophia went to live with her mother and had no contact with her father. After she told Dr Greenway about this, Dr Greenway diagnosed that *'in fact the devastation in her life was the fact that her story wasn't believed'*. Dr Greenway saw both Sophia and her father, *('a very angry man)'*, separately and then asked if they would come together and they agreed:

> *'When they met, I said the purpose of this session is for you to sit, non judgmentally and listen to your daughter's story...I got him to listen to his daughter's story, which took quite a long time. And then I said, now, do you think she's lying? ... Do you think she's being deliberately mischievous? And of course he said, No. So I said, O.K. Let's imagine that it took place. How would you react to her? And there was this amazing scene, because he said, I am so sorry, and went and gave her a big hug and they went off arm in arm together. Which was wonderful'.*

In our **third and final** interview, in early 98, I asked about Sophia's progress. Dr Greenway told me that he had had a telephone call from Sophia's father, informing him that everyone had:

> *'Gone back to their traditional role'*
>
> *'Q: And what does that mean?*
>
> *What that means is that Sophia has gone back to her mother, and that the Intervention Order against the father was not lifted, it's a load of nonsense.'*

It transpired that Sophia's mother had taken out an Intervention Order before Dr Greenway had held his meeting with both Sophia and her father. He had sought and obtained special permission to hold the meeting as it breached the order.

> *'You know, it was all so wonderful at the time, but absolutely nothing has happened, she's just gone back to living with her mum, and the Intervention Order's still in place. So I felt a little bit disappointed by all that.*
>
> *Q: Right. So in your belief there's no violence in that family?*
>
> *I can't answer that. But all I can say, the Intervention Order mentions violence and shaking and pushing and things like that, not heavy violence, in the sense of being beaten up. But that Sophia denied it. So it is all a very tangly mess'.*

Sophia and her father remain unreconciled. In order not to '*make huge tidal waves*' in the family, Dr Greenway, Sophia and her father decided not to report her grandfather to child protection services. Instead they would keep him away from her younger sister and tell her about what happened to Sophia.

1. 3 Dr Peter Greenway and Mr and Mrs Green

At our **final** interview in January 1998, Dr Greenway apologised for forgetting this case. For ten years, he has seen Mr and Mrs Green ' *who haven't got two bob to rub together* ' and their two children, now ten and seven, with whom he described '*an extremely happy and friendly relationship*'. Mr Green had been invalided because of his bad back, from the regular army into a civilian filing job. He then joined the Territorial Army (volunteer standing force). He saw Dr Greenway for back pain management and related workers' compensation issues. Mrs Green attended with the children or for herself, as she was a diabetic and required analgesia for chronic migraines. At some point in the past, with his back settlement, Mr Green had:

> *Treated himself to a Harley Davidson, or whatever it was, Triumph perhaps, I don't know, some sort of macho type motorcycle. But in fact the weekend it arrived he'd organised to go off for a weekend fishing with a friend of his, which he did. And his wife invited a mutual friend around and they rode off into the sunset on this motorbike, and bonked themselves into nonsense at a motel somewhere [laugh] and then told him'.*

The couple remained together. At about the middle of 1997, Mr Green was brought down from the bush by a friend, in full combat gear, camouflage and some self-mutilation. Dr Greenway commenced anti-depressant therapy and counselling with him. Dr Greenway has committed to counselling patients in his community one night a week at minimum, using a variety of self taught counselling modes, drawing strongly on motivational therapy.

> *'And in fact [he] was a poor attender. And was frequently late for his counselling, frequently turned up on the wrong day ... 'About a month before Christmas, unfortunately there was some very, very stupid argument about somebody had borrowed something and not returned it, or something really extremely trivial like that, which involved in the next door neighbour being assaulted and the police being involved. And in fact he's been charged and convicted of assault. And then about a fortnight before Christmas he started stalking his wife, and taking guns out of the gun cabinet, and ... his wife was absolutely petrified and went and locked herself in the garage and called the police, and the police arrived in all their flack jackets and various, blah, blah, blah, blah, night scopes, this all took place at night. And he was stalking around saying that if any of the police came he'd take them all with him and blah, blah, blah, blah, you know, all the usual bull-shit. Anyway, it all ended quite peacefully, and all his guns have been confiscated, and he's now on an Intervention Order to leave the home. He smashed up a bit of furniture, he smashed the back verandah. He didn't actually hit his wife.*

Dr Greenway commented that he would not have continued counselling with Mr. Green under other circumstances:

> *I've taken the view however, normally often, if the issues are not life threatening or too major, I tell people that I think that my counselling's not for them, if they do that, but with Mr Green in fact I've had an ongoing relationship, because I think that it's actually very important that he maintains some sort of contact.*
>
> *Q: Why was that?*
>
> *A: Because otherwise he's going to go up to the bush with a gun and camouflage paint... and he's going to either hurt himself or hurt somebody else'.*

Because of her past action, Dr Greenway thinks Mrs Green '*a little inflammatory to this whole process*'. He was surprised that the police haven't checked with him to see that Mr. Green was receiving care, as:

> *'Both Mr And Mrs Green know me well and would most very definitely mention me as their doctor, or the person to contact in a medical sense.... So if they haven't come to me, it's most unlikely that they've gone somewhere else...'*

Mrs Green has instituted an Intervention Order against her husband, the couple has separated and the bank has foreclosed on the family home.

2. Dr Jane Norton and her patients

Dr Jane Norton is an empathetic, single, quietly spoken, Anglo-Australian female GP, in her late twenties, two years into general practice and five years out of medical training. She has her Fellowship. She works three days a week at a family practice in a satellite town in the rural division and in town for a few sessions on other days. The satellite town has recently expanded and has many young families seeking less expensive housing. It consists of a largely non-NESB population. Dr Norton has worked in an inner city community health centre, where she managed a wide range of psychosocial issues, including drug and alcohol problems. The satellite family practice where she works employs an even balance of male and female doctors, some of whom are active in the division. The practice is well regarded for its participation in broader community health activities. She has since left this clinic and moved back into urban practice.

2.1 Dr Jane Norton and Mrs Davis

Dr Norton had presented this case, which she found difficult, in the first network session. In our first interview, August 1997, she introduced Mrs Davis, in her late thirties, with two children, nine and six, married to a man with manic depression, who sees a male colleague, Dr Kirkpatrick, in the same family practice. Although she had previously seen both the daughter and Mrs Davis with mild physical complaints earlier in the year, she described her first awareness of violence:

> *It would have been late May or June. And she said that she was putting on a lot of weight and she wanted to see a dietitian and do it properly. Then I went to do her blood pressure, I don't know why, but I did and she rolled up her sleeve and she had a large bruise on her arm and injury and quite quickly I said, how did this happen? And she burst into tears and said that her husband had hit her and that he'd actually hit the son, pushed the son ... and they'd left, and her parents live next door, so they'd actually left the house and gone next door and he'd sort of settled, the husband settled down and they'd come back. And this had happened about five days prior to her coming in and she really blamed herself. And she said, and that's why I think my weight has a lot to do with it, because I get obsessed about my weight, I always say, I'm so fat, blah, blah, blah and that gets him angry and that's why he snapped.*

Dr Norton responded under-confidently.

> *I think while she was telling me that story a lot of the thing was, Oh my God, what should I do? What can I do? What does she want me to do? And I think because not having had a lot of experience with it, there was a bit of panic I think... I felt very inadequate and very useless as a GP in that situation afterwards I guess, because nothing had happened. Nothing ... I hadn't resolved anything, or nothing had ... there was no step towards resolution or she just had sort of laid it on the table because it had happened, and I'd sort of left it there.*

In discussion, Mrs Davis insisted that she would ensure her husband saw Dr Kirkpatrick to discuss his medication and also informed Dr Norton that her parents 'felt that at any cost she should keep the marriage together'. Mrs Davis was concerned about her children's exposure to violence, as she had not experienced any in childhood and was concerned about the impact on them. Her husband subsequently went to Sydney for two weeks. Dr Norton gave her the name of a dietician.

Two months later, when we next spoke at our second interview, Mrs Davis:

> *'Came in and she wanted to talk to me about leaving and she felt things had got unbearable and she wanted some help with that. He hadn't been violent again but he was ... very dependent on her'.*

Mrs Davis told Dr Norton that she had returned to full-time work, but her husband still referred all decisions to her. She still did all the housework. Her depression had returned and she was having difficulty coping. In addition, Dr Norton discovered:

> *'He got this huge pay-out, something like $300,000. So he being the paranoiac says, well you only want me for my money ... he doesn't pay anything towards the house, luckily the house was paid off, but she really has to work ... but ... everything, the kids' clothing, food, bills, the car, she has to pay for that.'*

Dr Norton reported that she discussed Mrs Davis' worries about possible regrets, going back to part-time work, that Mrs Davis would see the CHC counsellor and that she had asked Mrs Davis to return in a week, but she hadn't. Dr Norton sees her role as supportive, a sounding board, and providing practical support, such as discussing work and finances and seeing the counsellor. She'd like to 'grab' Dr Kirkpatrick for a chat, as he has known them longer, but was concerned that she'd not be 'bombarding him too much'.

By Mid January 1998, our third interview, Mrs Davis had briefly attended to check her children's ears, as they the family were all flying to England for six weeks. She suggested that things were alright, but didn't seem to want to talk openly at that time.

By the fifth interview in May 1998, they had returned from overseas. Dr Norton reported:

'*She said that she's actually come in and seen Dr Kirkpatrick another time. And he, this was just after they got back from holiday or a bit earlier, and had been hit, I think in front of the kids again, and Dr Kirkpatrick who's the other GP, saw her husband, because her manic depressive husband was Dr Kirkpatrick's patient. Brought him in and adjusted his medication and counselled him. I think it was more the manic depression that was out of control at that stage. And Mrs Davis said, that from then, which was only a few months, he'd been much better and things had been much better.*

Mrs Davis' daughter had learnt to manage her father's illness and was very close to him. She begged her mother not to leave, even though Mrs Davis had said she would leave if hit another time. Dr Norton commented that Mrs Davis was again having trouble with managing her eating.

> *She did come into see me, because she's worried that she's heading down the pathway to bulimia again, and she wanted to do something about it. So I've actually referred her to the eating disorder clinic at the (large teaching hospital).*

Dr Norton would like to be able to liaise more effectively with her colleague, Dr Kirkpatrick but there was no protocol or practice for liaison over cases as such time was given to drug company lunches. She also finds that there was little time to liaise and that spare time was usually spent informally rather than discussing cases. At our final interview in late June, the cycle was returning:

> *She went to an eating disorder clinic, and the service they provided didn't really suit her, so she decided she'd come and see me every week to weigh in and she would get rid of her scales at home, and we would talk about the issues and talk about her diet and things like that. And she actually had an appointment with me yesterday but didn't turn up, so I don't know what happened there. But umm, her, but her husband has actually taken himself off the medication again, so she was worried that things may escalate. So that's where she was at the moment.'*

Dr Norton believes that Mrs Davis thinks it was a personal problem and more to do with mental illness than domestic violence. In reflecting on her role and Mrs Davis' needs, Dr Norton perceived that she needed:

> *I think some support and encouragement because she's the breadwinner and also the lynch pin of the whole family and she's really the carer for her husband who's got manic depression, and... it's really tiding her through at the moment and certainly it would be encouraging to see some progress with the eating disorder, but I imagine that would take many years anyway. That's not going to be a quick thing... But just to see her cope, and she does cope very well, so seeing her coping well and making sure she's not in any danger, but make sure that situation hasn't flared up at home was the goal, and would be her goal too, ...I mean she said herself she would leave in a second if it weren't for the kids. So just making sure that she's happy with that situation was really... I guess the loose goal. And really just riding the waves and see how it goes with her needs, if a crisis comes up and she does decide to leave, or does need support if he does hit her again.*

2.2 Dr Jane Norton and Mr Connor

Mr Connor in his thirties, had been sexually abused by his father when young and had spent time in prison and a psychiatric hospital. His mother, his main support, had developed profound dementia over the last few years. Formerly a truck-driver, after marital and alcohol problems following an affair, he developed back pain, became unemployed and his workers' compensation ran out. He was separated with custody of his oldest (14 year old) son. He was on a community-based order (no alcohol) and very, very poor.

Dr Norton introduced him in our fourth interview:

> *He's a lovely but frustrated guy...he's come in and he needs reports because he gets low back problems. He's also having a lot of trouble with his ex wife and he was put into jail I think for something he thinks, or he says he didn't do. And it seems very messy and ugly with the courts and everything, ... but he's very aware of what his limitations are, and he admits he's depressed, but the way he deals with it was with anger... I've only seen him once before yesterday, and then he said he's already spoken to someone about an anger management course, and his finances are terrible. So he came to me to get a doctor's report to access his superannuation, ...But he's got a lot of issues'.*

Dr Norton treated his pain and insomnia, but expressed concern at this point about potential suicide. Dr Norton had felt he was very caring towards his son and upset his son had to resort to getting refunds from shopping trolleys for some money. Mr Connor reported friction between his son and ex-wife.

At our fifth interview in May 98, Dr Norton reported the drama with Mr Connor the previous evening after he discovered his *anger management person* was sick and the CHC staff had not been able to reach him.

> *So he got very angry. And I saw him late yesterday evening, and he'd cut himself quite badly with a knife and was cut on his forearm, cut all his legs, through his jeans and was bleeding and had sort of these superficial but gaping wounds everywhere and was quite drunk, but quite calmed down.*

Dr Norton explained that it wasn't entirely unexpected as she had seen a lot of him and he had been experiencing major problems with '*the system*', as he was having financial difficulties accessing reports for his super, and was threatened with telephone and gas shut-offs. She was also concerned about his suicidal tendencies, believing his attachment to his son was keeping him alive.

> *And he's talked about killing himself, and how he could do it without ...his body being found, and yet, he's quite happy at the moment not to do that. But he's really's a very worrying case, and in a lot of ways, like I tried to make a contract with him one day when I was a bit worried he would suicide, and he said, oh look, I've done this hundreds of times, and there was no way he wanted to write anything down. He said it doesn't mean anything anyway, it's to save your neck.*

Dr Norton felt she wouldn't be able to call on the (mental health) Crisis Assessment Team, as it would breach the trust with Mr Connor, who was very 'anti-system'. She felt the best way was to treat him humanely and her previous undergraduate psychiatric training and experience, including working in an inner city CHC , helped her with the alcohol problems and blood. She also said:

> *I was a little annoyed but I thought being annoyed for him was not going to help at all. But I sort of let him know that I was annoyed, that I was trying to help him and he wasn't helping himself.*

Dr Norton told me of a poem Mr Connor showed her indicating his son's love and grave concern for his father. She hadn't been able to persuade Mr Connor to come in with his son. Mr Connor

said his son had friends, but no formal support. She didn't want to jeopardise his trust by pushing *that agenda.*

In our sixth and final interview, Dr Norton reported that Mr Connor was relieved by a milder, community sentence in his court case, and that she had been able to support him over the crisis and help him gain his superannuation. *'I just made a few phone calls while he was there, and that cheered him up, that someone was actually doing something for him I think. And the specialist was happy to waive the fee until he got paid.'* He was unwilling to deal with his alcohol problem yet or to discuss the impact on his son. Dr Norton says she was *'playing it by ear'* at this point.

2.3 Dr Jane Norton and Mrs Evans

In our third interview, Dr Norton told me of a new female patient, Mrs Evans, who had two sons, one of five years and another of ten months. Mrs Evans had come to see her, four days after her ordeal. She had seen her once before for a six week checkup after her last birth.

> *She came in, she had black or yellowing bruises under her arms, so it was quite obvious. So she couldn't, she didn't present, I sort of said, what happened? Straight away she told me. So it wasn't as if she'd presented with something else and I had to dig it out. She told me that her partner had, they'd fought over dinner and he had thrown a plate at her and had hit her across the face, and she couldn't remember a lot of the details. And she couldn't open her eyes the next day and she had painful upper arms. So I documented all that and right then she sort of said, also I think I might be pregnant. She was pregnant and that was the argument, that ... her second son was ten months at this stage and her husband, they'd been arguing over the fact that she could have been pregnant. And she, then knowing she was pregnant, she talked about having an abortion, because she thought she couldn't have more pressure on the relationship. But the reason she presented with this, was that she wanted to know if there was anywhere her husband could go for anger management, because he had wanted that. And he hadn't wanted to come in, but he had felt it was a problem that he had done this. He did it once when she was pregnant with her second son. And I think another time maybe earlier on, so it was about the third time he had ever hit her. And he had never hit the children. So she, you know, she was happy, she didn't want any intervention, she didn't want to leave him, she was quite happy to stay, she felt safe.*

Dr Norton gave Mrs Evans the name of the behaviour change group available at the CHC. She asked Mrs Evans to return to arrange the termination two days later, as she did not work at the centre the following day. Mrs Evans returned however the next day and saw another doctor to arrange the termination. Dr Norton was concerned about Mrs Evans's support networks and whether the husband had since attended the behaviour change group, but Mrs Evans hadn't returned.

3. Dr Sally Morris and her patients

Dr Sally Morris is a vivacious Anglo-Australian rural female GP in her mid to late 30s. She works 3 days, 12-16 hours a week at present, as she has a small child. She has been working in a small country town for only two years and has been building up her practice. The practice teaches on the RACGP training program and Dr Morris participates in the teaching. The practice has three full time male partners, an older three-quarter time female partner and a part-time male GP. Dr Morris has worked in an inner urban division and was able to compare her practice in this small comfortable and pretty country town with her experience in a multi-cultural inner city poorer population. In her urban practice she managed many cases connected with serious family dysfunction. She is actively involved in the rural division. She is strongly interested in counselling, among other GP skills.

3.1. Dr Sally Morris and Mrs Pickett

Dr Morris expressed concern about Mrs Pickett in our first interview. Mrs Pickett had been abused for over twenty years and had a 16 year old son. Dr Morris thought Mrs Pickett didn't have many friends or supportive family members. Some years ago, Mrs Pickett had been admitted to hospital with a nervous breakdown and had attended a support group for her addiction to Serepax. Her husband became very attentive and wooed her when she was in hospital, promising not to be abusive when she was discharged. Despite being depressed as her husband had resumed his abusive behaviour, Mrs Pickett was reluctant to take anti-depressants. Her husband not only abused her, but also threw away her medication. Dr Morris told me that at some point close to their first or second interview, Mrs Pickett asked her husband to leave.

> *I think we discussed what she'd been through, the effect that it had had on her...she discussed how she'd had a long time of this and it had destroyed her self confidence and her self esteem and she felt her son was learning not to respect her as well, and that he tended ... she was very concerned about the fact that he didn't exactly side with his father, but never supported her in any way when his father was around.*

> *He [her husband] had never been willing to seek treatment himself, and she talked about how she didn't feel she had the confidence [to leave], and she was nervous about the fact that she didn't think she would get her share of the value of the house etc. I remember talking to her about where she could get legal advice from, and we talked about an awful lot of things, and I actually spoke to her about self confidence and stuff like that..and also assertiveness, because she was kind of treated very badly at her work at that time too.*

Four or five months ago, Mrs Pickett had left her badly paid job and evicted her husband, although he was still harassing her, but to Dr Morris's frustration she hadn't followed up with counselling. Dr Morris had commented on her low weight and was concerned about either anorexia or bulimia. Since then, Mrs Pickett's chemist had rung expressing concern about the number of laxatives she was purchasing.

> *Each time I see her I arrange for her, I ask her to come back a week later or whatever, and she's now been like three or four times spaced apart by many months, and has never yet followed up on any of my referrals for counselling or support groups and never yet re-presented when I've asked her to. And in fact I'm feeling kind of torn between respecting her right to choose what she wants to do, and my wish that she would come in and get treated.*

Dr Morris had never seen Mrs Pickett's son, but she reflected that he would probably be confused, depressed and may not be coping well at school. Dr Morris didn't see her again until our fifth interview.

> *She came into see me, I don't know a couple of months ago, and we had a very interesting conversation, she had, she was feeling really, really happy and content in terms of her domestic violence situation, because she'd gotten rid of her husband once and for all kind of thing, because he'd been hassling her the time before that...And she'd started out, off her own bat, a sort of a group with other women that she knew of, who'd had problems with their husbands, or other problems, it wasn't just domestic violence, although most of them were I suspect. And she had just invited some of these people around on a regular weekly basis to have a cuppa and a chat. And it was quite interesting, because she was starting to feel like she was actually making a difference to some of these women.*

Dr Morris discussed Mrs Pickett's progress, her relationship with her son was going well and gently raised the issue of the laxatives and weight, but felt that she responded negatively. She had very high blood pressure and Dr Morris ordered a colonoscopy for a bowel problem, which Dr Morris thought may be associated with laxative abuse. Mrs Pickett didn't have either of the tests done nor re-present. Dr Morris felt really concerned about her, rang and left a message on her machine and wrote to her, but she still hadn't returned.

3.2. Dr Sally Morris and Mrs King

> *I'm counselling a woman who's been abused as a child, she was a victim of domestic violence, and also she was sexually abused by a man other than her father.*

Dr Morris discussed Mrs King with me at our second interview. She couldn't remember what Mrs King's presenting symptoms were, but reported she had soon picked up that Mrs King was depressed. Mrs King had experienced and witnessed domestic violence as a child. Her father beat her mother and the children. She suffered from low self-esteem and phobias. Mrs King was phobic about cars as she was raped in her car as an adult by a male stranger. She was phobic about speaking on the phone, as her abusive father was very controlling of her use of the phone as a young woman. Mrs King had two children with special needs and was involved with a committee for children with special needs. Dr Morris believed, as Dr Greenway does, that the CASA system, which Mrs King had experienced, hadn't shifted Mrs King's self esteem.

> *She had found that going through the CASA system had been good for her in addressing some of the issues.*
>
> *Q: Did she say which ones?*
>
> *A: It had been good for her in letting her come to understand that there were other people with similar problems.... So she learnt a lot about how people normally react and that she was reacting normally and dah de dah de dah. But they never addressed the issues of making her feel better about herself.*

Dr Morris described how she worked on Mrs King's self-esteem issues

> *I guess it's [my counselling] a mixture of things that I've picked up and things that I've read about from books, and things that I've just sort of thought of for myself, ...The sorts of things I do with self esteem though,... she's very afraid of being in the committee, and she thought she was an idiot and all this stuff,... so we talked about her writing. She's the treasurer, so I got her to write down lists of the things that she has done for the committee, the money that's she's brought in, things that would not have happened if she was not the treasurer. I also got her to do, she did the same thing with her confidence around her children, she thought she was a rotten mother, so I got her to write down a list of things that her children would have benefited from because she's their mother and nobody else. And got her to write down a list of ways in which she was better than her father as a parent.'*

Dr Morris didn't see her for a while until she had returned by our fourth interview. Dr Morris felt she had been happier and hadn't felt any need for counselling, but had returned with sexual problems.

> *She could never, she was never terribly comfortable with her husband initiating sex, she was much more comfortable when she initiated it, and various other sort of things that she liked and didn't like. She had a really good supportive husband, but she came in sort of saying that it had gotten to the point where her husband was so tentative about approaching her, that he was actually losing interest in sex altogether.*

Dr Morris spent several sessions counselling Mrs King and her husband around sexual relations. Dr Morris had asked Mrs King to write lists also of those things she found difficult. One had been the treasurer's speech she had to deliver at committee meetings. Dr Morris counselled her through relaxation skills and self-appreciation, which assisted Mrs King to become chairperson of the committee.

By our fifth interview, Mrs King attended with her children.

> *I've seen her since for sort of physical problems, because she comes and she brings her kids to see me too, so when she's come in I've sort of said to her, and how are you going with respect to other things. And she said, oh yeah, fine, sort of cruising along, and didn't want*

to talk about it any more, so I didn't push it any more....:So I don't know whether things have improved and she's content with it again now or what. [Laugh] But that's what I presume and hope.

3.3. Dr Sally Morris, the registrar and Mr and Mrs Nicholls

Dr Morris supervised a male registrar (trainee GP) at her practice. She told me about the couple for whom he had sought advice and her role in our second interview. Both couples had come from domestically abusive families. Mr Nicholls, a timid man, was violent only when drunk. Dr Morris had used knowledge gained from the training to advise J, the registrar, on referral agencies and counselling.

> *She came to see me with her husband once because the FMP registrar was treating her husband who's got a problem with domestic violence and alcoholism, and depression. Serious depression. And he asked me to review him on the weekend because he was concerned he might be suicidal. So she came in with her husband and I kind of looked at her and said, how are you coping with all of this, and she burst into tears and we had a long talk about her as well as him.*

I asked Dr Morris about talking to both partners together.

> *That worked quite well, he was actually fairly motivated and Jim [the registrar]has been sending him down to the CHC [behaviour change] program, and he's been going, and she's been going to the sort of wives half of it, and it actually went very well, because I raised some issues that had not been raised before about her and about her background. She has a background in which she had an alcoholic abusive father, and she had had a previous relationship was also abusive. So I told her that you know, women who had grown up in that kind of situation often ended up marrying men... that had the same sort of problem...I said to her that she was clearly depressed as well, and I pointed out it would have been more beneficial for their relationship and he would be more likely to succeed if she was also treated and both of them needed counselling rather than just him. And she was quite happy to go along with that.*
>
> *I also talked to the guy about his depression and about his tendency towards suicide and various other things, and it went very well in fact, because I think she wants to support him and he wants to support her. Like he had been talking about leaving the relationship because he felt it would be better for her and the kids, so we discussed that. But what ended up happening, I told her that she needed to seek counselling as well, and she elected to see Jim as well. Like Jim's his doctor, his GP...when I spoke to Jim about her later, because like she hadn't been treated at all, it was always her husband, I spoke to Jim about it and he said to me that he had asked how she was doing before, but she had denied any feelings of depression or whatever.*

The registrar had not had any formal counselling training, but had attended some CME domestic violence sessions and learnt from bringing cases to Dr Morris. She described her family systems approach to this -

> *[Mr Nicholls] felt his father didn't love his kids, and that he didn't care about them, and gave reasons why he believed still that this was so. So we talked about why he felt bad and he sort of talked about how he felt that he was a lot like his father and he felt he was useless and all this stuff. So I remember saying to him, well can you tell me anything that you know that's different about you and your father. And we talked about how that he was voluntarily seeking help and how his father never did, and how he had actually managed to stop drinking for nearly three months, except for the one time. And how his father never, ever stopped drinking. And we talked about how he did love his family and was concerned and wanted to improve things for them. We talked about how he showed his kids that he loved them ... we talked about him wanting his kids not to have the same sorts of opinions about him as he had about his father. And we talked about how he would like his children to describe him when they're grown up*

The registrar moved jobs and the Nicholls moved with him.

4. Dr Rosalie McLeish and her patients

Dr Rosalie McLeish is an empathic, single, Anglo-Australian GP in her late thirties who left a related profession and went into rural general practice six years ago. She lives and works in a country town with high unemployment. Due to a bureaucratic technicality, she doesn't have her vocational registration, which is financially disadvantageous. She practises almost full-time to maintain her salary although she would prefer not to, as she enjoys creative and other pursuits. She is interested in strengthening her counselling skills, as she sees a large number of patients with psychosocial problems. Dr McLeish has some sexual assault training and has worked with sexual assault services. She works six sessions at the rural practice, which has four EFT staff. Another female GP does a few sessions, whereas the other full time GPs are male.

4.1 Dr Rosalie McLeish and Mrs Robinson

Dr McLeish is very cautious about patient confidentiality. In our **fifth** interview, she told me about Mrs. Robinson. This story describes, albeit sparsely, a response to abuse which Dr McLeish had recently uncovered. Mrs Robinson has been seeing Dr McLeish for a chronic medical issue for a long time. She was in her 50s and Dr McLeish can't recall how she became aware that Mrs Robinson, a home-maker, was denied sufficient money to live on.

> *'I don't normally sit down and go through someone's finances, but...you know, you sort of get a ... we just sat and talked about things.'*

Dr McLeish discussed her strategy of referring Mrs Robinson to accountants and telling her *'that she has value'*. She didn't think there was any other abuse, but she knew that Mr Robinson was 'affluent' and Mrs Robinson wasn't allowed enough to live on.

Dr McLeish expressed concern that with the success of some 'empowerment' strategies she had used over the last few months, Mr Robinson's 'behaviour' and 'agitation' might escalate. She was worried all the precautions she advised and the safety plans may not be adequate.

In our **next (and final)** interview, she reported later developments. She then revealed what she had consequently found out and was quite shocked that Mrs Robinson:

> *Wasn't getting enough money...to survive... and she wasn't allowed access to the car, she wasn't allowed access to the phone, she couldn't get out of the house because she couldn't get access to the keys.... I didn't realise how severe it was.'*

When I asked how she was able to help Mrs Robinson if she was so isolated, Dr McLeish told me how, because Mrs Robinson was allowed to come to the doctors for her illness, she organised help while Mrs Robinson was in the consulting room with her and had all documents sent to the clinic, so she could pick them up while she was there. She wasn't aware how the lawyer she had recommended had contacted the woman, but she was able to pick all relevant documents at the clinic. Clearly it had gone to the courts. Dr McLeish reported that the outcome was good and that the courts had ordered Mr. Robinson to *'do all sorts of things'*. She was relieved that the danger to which she thought Mrs Robinson may be vulnerable as a result of standing up for her rights hadn't transpired.

4.2. Dr Rosalie McLeish and Alma Matthews

Dr McLeish told me the story of an older woman whom she gave as an example of her empowerment strategies. The woman had disclosed to her and she had been seeing her every few months:

> *I think she just broke down on me one day and I just allowed her to keep crying and then I don't know, I think just because I didn't sort of push her out the door and I just hung in there, it eventually, it just sort of cascaded out I think... I don't know that I particularly changed her life, but I've made her life more bearable, because she's staying within the same [tape fault] situation ... to be herself and do things she wants to do, instead of just putting up with, you know, waiting for him to come home from that last affair.*

Dr McLeish spoke of the importance of Alma coming to trust that she could speak about any aspect of her husband's behaviour and Dr McLeish would not judge her for staying. She described Alma's gradual unfolding of the vague (probably sexual) forms of abuse from her husband:

> *Even six months ago she came out and told me stuff about what he does, I was just horrified. It's not so much, it's not like he beats her, ... it's more, you know just some things people do or say are really creepy and disgusting...she tells me things, like she says because she can come and tell me things that he does, it enables her to exist, because she can off load it onto me. ... and it's someone she can, I guess debrief with'*

Dr McLeish has discussed the fact with Alma that the abuse is patently unacceptable and she is not responsible for it and believes Alma knows this, but still doesn't feel able to leave:

> *She just doesn't feel she has the strength to be on her own. She's never been on her own in sixty years. She doesn't think she can do it. But she can be on her own within the marriage. She can go and do things for herself now, which she never did. She has a life outside the marriage.*

Dr McLeish believed that the most effective aspect of her strategy was to be able to allow Alma to tell her whatever *'disgusting stuff'* her husband had done but to reaffirm to her that it had not *'tainted her in any way, she was still a nice person'*. She now saw Alma every few months.

After a few interviews passed by, Dr McLeish told me of a serendipitous occasion when both Alma and her husband were in the same hospital, as he had had a stroke. She was able to persuade the same social worker to see both of them and the social worker discovered the abuse, which she thinks has been helpful.

As Dr McLeish had admitted Alma to the hospital for a physical illness, she used the opportunity to visit her and spend more time talking to her. Dr McLeish believes the hospital was a useful resource for rural GPs with abused patients - to give them time out. It was far more difficult to do with the advent of diagnostic related groups (DRG) as a funding base for hospitals, as abuse was not considered a DRG.

4.3 Dr Rosalie McLeish and Annette and her partner

Dr McLeish had an antenatal patient aged 19, whom she had cared for when Annette was pregnant two years ago. She described the abuse Annette experienced as psychological, although she didn't discover this until the postnatal period, as she realised Annette hadn't perceive it as abusive. She said Annette tends to come and go in the practice, turning up when things are bad. It wasn't until Dr McLeish admitted her into hospital with serious postnatal depression that she was able to observe Annette's partner's behaviour.

> *He would come and visit and it was quite obvious that his behaviour was just atrocious.*
>
> *Q: What was he doing?*
>
> *A: Well, just totally dismissive, sort of saying she was hopeless, because she couldn't get her act together, and she should be able to get her act together and get out of this, she should be home looking after the baby and she wasn't a good mother, and all that sort of thing.'*

Annette had been admitted to hospital a few times and had been referred to the Grey Sisters (in-patient care for postnatal women) for some time out and help with the baby. Dr McLeish was very hesitant and under-confident at this point about her own strategies and counselling. She had volunteered for the training to gain confidence in this area.

> *Well I just sort of wade through it I guess.*
>
> *Q: So you provided her with some time out. You provided her with ...*
>
> *A: With someone to care for the baby.*

At this point, Dr McLeish was referring to the 'cuddle mums', a rural resource of volunteer women who come into the hospital and give support and respite to depressed new mothers. She didn't believe that Annette's relationship would last. Dr McLeish said that she worked on self-esteem issues with Annette, her appearance and her value. She didn't engage with Annette's partner.

Annette had post-natal depression for a year, left her partner for some time and then they reunited and as a couple self-referred for relationship counselling with another provider. By our **third** interview, Dr McLeish said they had done quite well and Annette was pregnant again. Unfortunately, as Dr McLeish no longer felt able to do deliveries, she wasn't seeing Annette any more and didn't know her current progress.

4.4 Dr Rosalie McLeish, Rose and Jethro

In our **third** interview, Dr McLeish spoke of an unemployed couple in their 40s she first thought were a 'classic domestic violence case'. Rose was alleging abuse from Jethro, but didn't want to leave. When she first introduced them, she had been counselling Rose for five months. Dr McLeish tried some counselling techniques she had learned from the domestic violence project's crisis counselling workshop on techniques of breaking destructive cyclic arguments. Rose and Jethro had tried this and found it useful. On the day of our interview, Jethro had phoned her alleging Rose was abusive, crazy and may harm both herself and him. He suggested she needed treatment. Dr McLeish was quite worried, but had decided firmly she could not see both of them and referred him to another counsellor, who was skilled in drug and alcohol work, but whom she believed had relationship counselling skills. Dr McLeish, who was quite hesitant, explained why she did this:

> *It's important not to then appear to be siding with another party. I might be wrong, ...I'm happy to treat both partners as a couple, and I would be quite happy to, if they're both working together. But if, in this case I think I'm getting different stories from each person, because I had one as the presenting partner, I think it's important that I not lose her trust or that relationship.*

Dr McLeish tells me Jethro alleged she wasn't getting the 'right story' and Rose was the problem. However, Dr McLeish didn't feel that accepting his version was appropriate:

> *She's coming to me with a presenting problem and it's my, I don't know if this is right or not, but I perceive my role as being, treating what she perceives as being her problem ... She perceives him as being the problem. And what I've been focussing on is that it's the couple together. That the two of them together are creating the problem. That it's a problem between the two of them. And he actually thinks it's her that's the problem ...It's more emotional violence. He tells her all the time that she's crazy... what I think was happening was he can't deal with the fact she's getting stronger, so therefore he has to knock her down. So that's why I think it's better that I don't collude with him.*

I informed Dr McLeish that I knew of several women whose husbands had tried to have them sectioned into psychiatric hospital alleging their responses to abuse meant they were crazy. She said Jethro was suggesting this. As the other counsellor was someone with whom she occasionally debriefed, Dr McLeish thought she would discuss issues with her for case management.

In our **fourth** interview, Dr McLeish said she had been working on self-esteem issues with Rose. They both threw things around the house, but she perceived they were now equally strong. They were communicating better.

By the **fifth** interview, Dr McLeish told me Jethro had not gone to see her friend, but they both saw another counsellor, which was also helping. She thought they were both probably emotionally abusive and threw things. Dr McLeish had discussed Rose's past with her and different anger management strategies. She had also discovered that one of Jethro's parents had suicided, and that may have coloured his fears about Rose. She also believed that because Rose lived with Jethro in his house, she didn't have a space of her own. They weren't yet able to build a house they both owned. Rose had since negotiated a room of her own and felt she could now assert and discuss her needs.

> *I think after a while maybe they realised the relationship's worth salvaging and they do it, I don't know. I don't think we can wholly take responsibility for the improvement. I think we are an adjunct to the patients making their own improvement. I think in order for it to work they've both got to do it themselves, we really just facilitate that.*

By the sixth interview, she reported that they were very happy and were now building a house together and *'I think they have worked through a lot of stuff together, it's gone well.'*

The urban GPs

5. Dr Harold Rosario and his patients

Dr Harold Rosario is a full time solo male doctor in his mid fifties from Southern Europe, who conducts his family practice from his extended house in an outer suburb of the inner city. He employs his daughters as receptionists and his wife as practice manager. He enjoys practising as a family doctor in the 'old style', conducting home visits and valuing his longstanding relationships with his patients. In his home country, Dr Rosario had trained in and practised marriage guidance, as well as medical practice. Dr Rosario takes trouble to remain up to date and informed on developments in professional training. His work is informed by his strong Christian beliefs and he is active in his church community. He is very involved in his ethnic community also, particularly in the Arts. His patients are predominantly from his community.

5.1 Dr Harold Rosario and Mr and Mrs Starelli

In his **first** interview Dr Rosario described a recent incident with a couple from his country he had been seeing for some years. Mr Starelli, in his mid 50s, was on a disability pension for cardiac and back problems, but works on the black market in car repairs. Mrs Starelli works against his wishes, as he was concerned his pension may be diminished. Dr Rosario describes the fact that they have '*very bad clashes*'. '*They have nothing in common, but they fight all the time. And he still wants sex. And there was no love, he's just satisfying his sexual urge.*' He characterises the relationship as one of mutual jealousy and mistrust from the beginning. He had previously tried some mediating couple counselling with them '*to prevent them from arguing*', but it had not worked. He sees them as *'stuck together in a kind of spiral, where they live together just to argue and fight'* and have done so for twenty years. Dr Rosario expresses surprise that both individuals come to him:

> *It's amazing, these two people, they both come to me, they come to the same person, and both of them, from very different angles and yet expect advice which is applicable to their own particular case. It's very funny, because normally you go to different persons.*

He believes it is good as he can see the problem from both points of view, but believes she is partly to blame for provoking ... '*actually I feel for him, because I know what he's going through. She's not the only one whose suffering*' He thought they had both been to lawyers.

After a recent 'clash', Mrs Starelli had called him on Saturday after she was hit, wanting immediate help, but cancelled when he couldn't come for a few hours. She presented on Monday with bruising and tenderness to the head, where she had been hit. She didn't want to call the police, but had used the police before and her husband had '*used that against her*'. Her husband is fearful of jail, although threatened to hit her so that she would call the police. Dr Rosario reflected that there probably wasn't any real danger he would kill her ...'*because when he hits her, he's just in a fit of anger, he's not aiming to kill her, but...because in a way now, she does set him up. She uses words in such a way to taunt him.*' He was at pains to say that she needn't obey, but that he '*wouldn't like to live with her, as she is provocative...and then when she is hit, she starts stammering and crying. I'm not saying that she deserves to be hit, what I'm saying is that there is some provocation, and some people can't take that.*' Dr Rosario asked Mr Starelli:

> *Why do you hit her? He said, Oh because she provokes me ... then I hit out at her. So he's not ashamed about what he does, he doesn't even sound sorry. Hitting is his right to do, because she's so stupid as to provoke him and to continue to do it. And I said, you're going to end up in prison if you keep on doing that. He said, yeah, I think so.*

Dr Rosario firmly believes in separation when there is violence. He has constantly advised Mrs Starelli to leave. Dr Rosario reports that she doesn't want to leave before they sell the house '*because she will have nothing*'. I ask if she is worried about money. Dr Rosario tells me that most of the arguments in every home are about money. He has also suggested she go on a holiday somewhere else, which she doesn't want to do either. '*Its difficult*'. He has spoken to her about change, but she says she's not going to change. '*She's convinced she has nothing wrong with her - when I say, why do you taunt him and say do this and do that.*'

He suggested counselling for assertiveness and recently gave her copy of a booklet which outlines rights and resources for abused women. Dr Rosario says he wanted the self-righteous man to learn other ways to respond other than by hitting. He referred him to the men's telephone counselling and referral service, expecting the man to be referred to a local male behaviour change group. Unfortunately it backfired when they suggested legal aid and the service did not respond well to Dr Rosario 's criticism. He referred the man to another men's behaviour change group, but he hadn't yet attended.

Postscript: Mr and Mrs Starelli finally sold their house and have moved to Queensland 'to start a new life together'. Dr Rosario has not heard from them.

5.2. Dr Harold Rosario and the Montari family

Seven years ago Mrs Montari, separated, in her sixties and from Dr Rosario 's own community came to see him for her blood pressure and weight. He describes her as a '*very, very gentle and pleasant woman*'. As he got to know her, she gradually disclosed:

> *Stories where she was beaten by the husband, he wanted to have sex... and she had no say in it. He used to beat the children, he used to drink heavily and he'd think that all these things were his privilege ...This is a phenomenon among men, there is an attitude that she deserves it, he's OK, he never had anything wrong with him ...There are several men who ... terrorise their family, but they are like lambs outside. It's almost impossible to tell that man is inflicting violence, he behaves in such a kind and respectful way towards others.*

In our first interview he says '*a few years ago, she plucked up enough courage. I suppose due to the help I used to give her...to divorce him.... I told her what to do*'. Her husband had gone back home overseas and was due to return. Although they had separated, she was afraid he wanted to return to the marital home and would beat her. He advised her the man had no right to return to the home and her sons helped prevent him returning. In a later interview, it transpired Dr Rosario had, as a lay apostle of the Catholic church, warned her against divorce and when she went ahead, stressed that she was civilly but not religiously divorced. He understood that she needed this to legally restrain her ex-husband from returning to the marital house. '*I said OK, you've done the right thing but remember that in our religion, divorce doesn't figure at all, it's only from a civil...* and she said '*OK, that's fine, I believe that*'.

Dr Rosario described how he had told her she needed to learn to swim for her arthritis and even though she couldn't, she had learnt to swim at 64. She was '*a very motivated person. she's the best swimmer of the lot*'. She continued to see him for medical reasons and discussed what was happening with her children, some of whom Dr Rosario also saw. He believed that they have all been adversely affected.

He described the impact on her sons. They are '*very timid and ...if someone tramples on their rights they just accept it.*' One daughter was hastily married and the other, whom he saw regularly, '*reacted a lot against society in general*', had been promiscuous and had several serious STDs. She was a '*faithful patient*'. She was now in an abusive relationship with a male refugee to whom she felt grateful because he stayed with her during and after her troubled years. He described this young woman as one who left her partner and then '*he calls her back and she goes.*'. He has constantly advised her to leave, particularly as she was not engaged and may not marry him.

> *I have no qualms at all at saying, look, you're not married together...only an emotional attachment, if he's not the person you would like to spend the rest of your life with, what are you doing?*

He asked me... '*It's also a man who does this to her. Hit her. Why did this happen? When a daughter was hurt by a father...why does she always find a violent man to live with?*' .Dr Rosario believes that previously he would not have asked about someone's private life, if a doctor suspects abuse, but '*now I know that it is ethically and professionally correct*'.

5.3 Dr Harold Rosario and Mr and Mrs Mizzi

Dr Rosario told the story of a couple in their mid 40s, who saw him regularly, both separately and together. Mrs Mizzi, whom he has known since she was a child in his country, is overweight and epileptic. Mr Mizzi's father had been an authoritarian despot in his family, and Mr Mizzi has a Syndrome X, is hypertensive and diabetic. They have three sons, the oldest of whom left home.

> *I'll digress, I had a woman this morning, whose husband is very abusive. He doesn't hit her, it's a different kind of abuse. He wants sex, and he wants it now. And you've got to do ... if you've got something ... I don't care, I want you for three hours. And you have to be with me. And he has problems with impotence. So she has to be very patient with him, to help him, to get what he wants. And he's extremely demanding, and he's also too stern and too difficult with the kids, he hits them and he doesn't praise them if they do something right, just tells them when they do something wrong.*

While Mrs Mizzi has nursing qualifications:

> *He can't read, he can't write and he can't work. He's been on the disability pension because of back pain since he was about 35. Not a very good role model for the kids. One of their children, by now he is 20... when he was 14 he left home.*

Dr Rosario takes opportunities when he sees them alone to raise the issue of abuse.

> *Q: Have you talked to him about it?*
>
> *A: Yes. He says, No, I'm OK I'm OK. He denies it. No, no, it's OK and he's a bit secretive about sex and things like that, as most of the [culture] are. They don't want to reveal, that's taboo because that's something for the bedroom only.*

Dr Rosario has informed Mrs Mizzi that she is abused and has shown her 'Mirrors, Windows and Doors', which describes cases of abuse by men including sexual abuse. It is addressed to men and women directly as a self-help book. Dr Rosario recognised some of his male patients in the book - he puzzled over them:

> *They are wolves at home, but everywhere else they are timid and they will do a favour for you, go to the end of the world for you, but then in their family life they stand stiff and authoritarian, and to the extent of abusing, physically or verbally. It must be some kind of medical syndrome without a name to it.*

Dr Rosario saw the sons very occasionally and expressed concern for the youngest, who was almost 14.

> *Once she brought him in here, and I saw his eyes, there were tears, and I asked him, are you depressed, what's happening at home? And he said, Oh, it's the usual things, his father is angry with him, and he beats him if he doesn't obey, and he finds the slightest excuse to punish his sons physically. No wonder they want to leave home and get a job.*

Dr Rosario suggested that Mrs Mizzi counsel her son, as he has little contact with them himself. He found it professionally difficult also to see the mother alone or ring her at home.

> *Because when I have to deal with her, I have to do it behind his back, because he denies it, so .... I'm in a bit of a difficult position there ... In the uncultured mind, goodness knows what paranoid ideas. She wants to see the doctor alone, why? Goodness knows. So I have to be careful.'*

I asked Dr Rosario what his goals were with her, as she doesn't want to divorce or separate at the moment.

> *Preferably at least help her to become more assertive, more able to stand up to him and say, no, you mustn't do this to me. I'm not happy, I don't feel well, you've got to stop today,*

and we'll make an appointment for tomorrow, or whatever, but he's so ignorant. I want it now. And to keep on insisting. And I think sometimes he forces her... Eating is seen as a solution to the worry problem. Unless we can break that cycle, I worry, therefore I eat.

Postscript: *There seems to have been a temporary improvement in this family as well. The eldest son has since come home and seems to have mellowed in his behaviour towards the father. The parents are about to go on a long holiday to Europe together and appear happier and more united than ever before.* ***I think the patience and the counselling produce results, if one is prepared to wait!***

6. Dr Jill McPherson and her patients

Dr Jill McPherson is a vivacious 33 year old Anglo-Australian female doctor, with two small children, who works part-time (five sessions) in a maternal and child health clinical outpost of a large inner urban Community Health Centre (CHC). The clinic is situated amongst houses in a very deprived inner urban area on the outskirts of an industrial estate. There are two female doctors at this clinic, while there are 10 EFT doctors at the main CHC. The area has a high proportion of NESB communities, including Turkish and Arabic speaking Muslim people. Dr McPherson has travelled to Turkey. The clinic employs a social worker and Dr McPherson is a regular user of the social worker, the CHC's bilingual workers and the Community Health Interpreting Service. She has worked at the clinic for eight years.

6.1 Dr Jill McPherson and the Turko-Kurdish couple

In our **third** interview, Dr McPherson raised this case of a man using violence. Mr Yusuf came to Australia about eight years ago for an arranged marriage with his wife, who grew up in Australia and spoke good English. Mr Yusuf had injured his back badly at work.

> *He was a delightful happy person, unfortunately with workers' compensation, they lost the house. They lost [his job] ... he lost all his respect from his community. He hadn't understood the workers' compensation system, coming from a rural part of Turkey and a Kurdish background ... and just assumed you had to keep on working, even if you were in pain, because otherwise who's going to look after your family?*

After losing his workers' compensation case initially, Mr Yusuf came to see Dr McPherson who advised him to have back surgery. After surgery, he suffered reactive depression. Dr McPherson gradually understood, when she finally saw his case-notes, that he didn't really understand English properly and people had seriously misinterpreted his case. She made sure that every time he saw any one, he had an interpreter as *'he was stuffing up his case. Even though he appeared to have reasonable English... you were missing really important stuff.'*

Mr Yusuf's wife was a very popular community member and trusted by many families as their preferred interpreter even when Dr McPherson , a stickler for appropriate process with NESB patients, offered the accredited CHIS interpreters. Dr McPherson had hoped Mrs Yusuf could be trained as an interpreter but her illiteracy prevents this. She had been doing supportive counselling with her and was hoping to support her to learn to read and write. Mrs Yusuf had been badly abused as a child herself, which emerged when the marriage struck trouble and both partners came to see Dr McPherson. As well as depression and suicidal ideation, he psychologically abused his wife:

> *On two occasions it extended to limited physical violence. He slapped her once and she's a very assertive woman. She said, its not on and told everyone ... [Laugh] Which was a very good approach in fact because it really made him realise that it wasn't going to be hidden if he did anything... But he was guilt ridden with it.*

After the violence emerged, Dr McPherson found Mr Yusuf blamed his situation, saying that sometimes he lost control. She discussed the fact that he did have some control and should be using it to restrain his violence. She believed there had been no further violence, but attributed this not only to her advice, but to the fact that she helped him win his workers' compensation case and he regained self-respect and respect from his community. It validated his injury. However she also believed that it was important his wife had disclosed his violence not only communally, but in front of her. Mrs Yusuf spoke of her severe childhood abuse and her husband did not attempt to defend himself, but agreed that she did not deserve this kind of treatment.

> *She just said, you know, when she came in, This was what he did to me. As if I'm going to put up with that! As if I haven't been through enough...She was, he was sort of sitting there going, she's quite right you know. He's very umm, he's been aware of the fact that she's had this terrible childhood, and I think that added to his guilt. So instead of excusing his behaviour, which was one of the problems we sort of sometimes see, you know, she obviously asked for it, it's happened before, you know. There's something about her, or whatever. There was none of that at all.*

Dr McPherson lent her authority to Mrs Yusuf's shaming and Mr Yusuf accepted the guilt. She spoke of the importance of asking about related domestic and workers' compensation issues:

> *I always insisted with my workers' compensation patients that we explore the emotional issues, the home issues, all of those aspects. I don't think you ever treat anyone just for the particular workers' compensation injury. You've got to always assume that it's going to have a great impact on other areas of their life.*

In our final interview, Dr McPherson wasn't sure about the future for Mr and Mrs Yusuf. He had gone back to visit Turkey and they were buying a new house. There had been no abuse of any kind, but she would just wait and see.

6.2 Dr Jill McPherson and the Maltese couple.

I have quoted this case from our first interview virtually verbatim (except for creating paragraphs), as it was quite complete and Dr McPherson was remarkably honest about what she learned from it.

They were an interesting couple. They were, I think Maltese and in fact I'd been seeing them both for a long period of time and had developed quite a rapport. There was a, you know, a shared sense of humour and we often had tales, you know, you probably shouldn't be going so far along that line in consultations but we had a set of things that we enjoyed talking about. And in fact, I was so close that when I had my first child the wife made a beautiful woollen crocheted rug for my baby. And it was just such a blessing. I often get presents but that was something that obviously had a lot of time and effort put in. And I had been doing some supportive counselling as well when I saw her alone. But I hadn't actually sort of guessed that a lot of her stress was related to domestic violence. I thought it was related to him being an extremely anxious person, feeling displaced in our society and wanting to go home. O.K. And putting pressure on her that she should leave the child in Australia and go back. And she couldn't bear to leave. So I thought it was all connected to that.

Then one day she came in and she, during an examination it was obvious that there was a bit of bruising and I inquired what was going on and she cried and told me about what had happened. Said it only happened every year or so, that she was considering leaving him after this particular episode, but knew that she wouldn't ... and said look, he's just so stressed he needs to come and get some help. So he came in, right, expecting ... because I was actually seeing him for anxiety and depression, he was actually on medication for depression, a simple tricyclic anti depressant, and had seemed very well controlled in the sort of preceding, I suppose, six months. And so we got into enjoying having some reconnoitring different adventures of his life. Then, so I was talking, using the usual depression and he'd been talking about he had a bit of an anger problem and he wanted to work on ways to work with his anger so he didn't get so angry. And I thought, oh this was a natural time to lead into this. You know, sort of what do you do when you feel angry sort of stuff. I didn't word it quite so well, and since doing this course, but the basis test was there. And he was OK, he was heading along, and then just suddenly he looked at me and just like, She has told you, hasn't she? And he stormed out of the room.

I telephoned his wife immediately and said, I hope I haven't caused some problems, I can't say what your husband was saying to me, but I think he may have realised that in the previous time you attended me what was going on. And he came storming into the house actually during the phone call and I tried ringing back, and he was really angry, slamming the phone down and he said that's it, we'll never see you again. And, literally never did see me again.

I know I rang her on one other occasion just to see how things were going, and she said, No, I can't see you. And it was obviously that he had felt that he had developed some level of rapport and he felt really ashamed I think, and couldn't bear the thought of facing, or his wife facing me. And I guess it was also a sense of his wife had betrayed him to me... And that has been such a lesson to me. It really upset me. I had to get a little bit of peer support at the time. I used one of our psychologists to try and help work through the issues and how it affected me.

6.3 Dr Jill McPherson , Roslyn and Bill

In our **first** interview, Dr McPherson recounted an incident two days previously where a long term patient, Roslyn, 27 (who had been abused as a child) and her partner Bill, in his late 30s, had seen another doctor at the clinic. They presented because Roslyn had hit her older daughter. The couple had another child 18 months old. Yesterday, they had come to see her and Roslyn said:

> *I had to tell her that I was hitting Jenny, and I threw her across the room and she's only four years old, and it's not her fault. I'm sure it's because my partner, he sort of shoves and pushes me, but it's not because of her ... you know, and she was going on and on. And the father came in, absolutely off his head, furious with me because he knows me too, and he's going, you know, you betrayed me, you let me down, you've reported it to the bloody [child protection services] CSV, how dare those mongrels come to my door.*

Dr McPherson described how she thought Roslyn felt about her actions:

> *She was abused as a kid. It seems that her mother was really nasty to her, made her feel like she was a really bad person, because she did go off like a rocket a fair bit in her teenage years. And she said I started to do that to my daughter. I say to her, you're bad, and I hate myself. She said, I feel heartbroken, I feel so guilty. That in that moment I'll do anything just to hurt other people around me, so that they know how much I'm hurting inside.*

Dr McPherson organised a psychiatric assessment for Roslyn, as she was very depressed and had spoken to child protection services about parenting support for her also. I asked her about Bill, whom she described as *'extremely resistant'*. He claimed that '*we already decided that it's not acceptable that she does this... and we have decided that my partner is going to have help... and I don't see what the hell CSV has got to do with it.*' Dr McPherson explained that as Bill could be violent, she wanted to defuse him immediately, as he thought her colleague had reported the child abuse (she hadn't) and she persuaded him not to physically attack child protection staff, but express his anger.

In our **second** interview, Dr McPherson reported that the psychiatrist thought Roslyn had some anti-social traits and needed drug treatment, but was not significantly depressed. The psychiatrist said she needed to accept responsibility for motherhood. She was attending counselling, drug treatment and Dr McPherson . According to Bill, however, several days ago, she had vanished with Bill's best friend who was down for a visit, saying she didn't want such responsibility. On Dr McPherson 's questioning, Bill asserts there had been no violence or arguments on his part.

> *So he's now left with the full child care of his kids and trying to work. But the really interesting thing is, for all his anti CSV stuff before, he said, I rang CSV just to fill them in, because she didn't turn up for one of her appointments, and they were really good. They offered to organise cheaper child care, day care rates for me and things like that, so it's good to know they're in the background. It's a turnabout and a half. He laughed at me when he was telling me this.*

Dr McPherson believed Bill was well supported both by her and CSV. She had spent time with Roslyn, who believed that '*she deserved it [the abuse] anyway because she was being a bitch, and therefore it was his right to knock her about a little bit'*. Dr McPherson counselled her that it was neither valid to use physical or emotional violence on her children, nor her partner with her. She wondered whether Roslyn had decided to leave Bill because of this.

She was very aware of four year old Jenny's needs.

> *She's experiencing some abuse herself, but also she's obviously witnessing domestic violence from the scenarios that they're describing... But I also talked to her today about who she finds she can talk to the most, and she actually pointed out that she talked to her dad. But that's about how she feels about her mother leaving in this way. And I don't think talking to your dad who was a perpetrator of violence about the domestic violence would be the go. I'm sure they [children] talk to their mothers about it as a victim, but the mother's*

often so involved in her own emotional reaction to her abuse, and feeling guilty because she'll feel hurt, but [also feeling] she was guilty for the children witnessing and experiencing it. So the woman's so caught up in that that she won't be truly listening to the child's needs within it.

By the **third** interview, Roslyn had returned to Bill. Dr McPherson said that she *'came in with one of the kids, but had to whiz in and whiz out. To get back to pick up the other child. But she was in the honeymoon stage.'* Dr McPherson also spoke about trying to speak to children alone. Through this she found out that Jenny had time out often with her mother's best friend, who was *'very cluey':*

This woman is very aware of the whole situation. She is a very open person to talk to, and I think kids feel she's really non judgemental, and she'd be seeing her a lot more than she sees me, and this woman has rung me and said, are you aware that this was going on... so she also sees that she needs to be feeding back into the system and she knows that there are accepted strategies, she knows about CSV. And I think that someone like that and knowing that she sees her regularly was also good to know about.

Dr McPherson expressed frustration with child protection services' lack of feedback. Although it was likely the mental health worker had referred the family to CSV, she was not aware whether they knew about the domestic violence, nor whether as a result, either partner or the children were receiving any management for it.

In the fourth and **final** interview, Dr McPherson had been ill herself and had only returned to work two weeks before. She thought Roslyn still in a honeymoon phase, but had not seen either partner or children since our last interview. She perceived that:

It's important for her that people are consistent and give her unconditional regard, and that is one of the important roles that I have and I think it's certainly helped her to have someone who she has told a lot about herself to, and would expect you to hate her for it at times, and to be able to say, look that particular behaviour, such as the actions with her daughter, that's not acceptable, but you don't accept or want it either, Roslyn. You want to be better than that, you want to be a better mum than that, you want to be in a better relationship, so that although you're encouraging positive change, you're still not rejecting her as a person in the process.

[Bil])'s not attending any anger management or programs per se. His response has been that now that he's decided it's not acceptable behaviour, because before that he actually seemed to think it was, and had worked out a series of justifications, but with all this intervention I think he has come to realise that it's not considered acceptable and he had decided to make some changes. Now whether or not that will be enough, or whether he will find that he will lapse and require some support in achieving the change he'd like to, we'll just have to wait and see.

7 Dr Errol Threadgold and his patients

Dr Errol Threadgold is an energetic Anglo-Australian male urban GP, in his forties, with teenage children. He works in a very working class, multi-racial, industrial area of Melbourne. The private clinic in which he is a partner is multi-disciplinary, with both a pharmacy and pathology clinic attached. It contains consulting rooms for both GPs and specialists, including rooms for paediatric specialists. It employs physiotherapists, Turkish and Arabic speaking psychologists and receptionists and specialises in workers' compensation issues. Dr Threadgold has attended cross-cultural educational sessions and actively attempted to read and understand cross-cultural issues for his NESB patient community. He has been very involved in the division and is active, informed and interested in wider GP policy issues.

7.1 Dr Errol Threadgold, Jack and Andrea

In our **first** interview, Dr Threadgold introduced an Anglo-Australian couple, aged in their mid 30s. Jack, *'a 'passive, aggressive'* white New Zealander, a *'big bloke and pretty heavily tattooed'* and Andrea, *'pretty dramatic... aggressive at times'*. Dr Threadgold thinks they are '*both probably abusive*.' Jack, a truckie, has been unemployed for six months. When he works, '*he uses speed or Duramine to keep himself awake and drinks a bit on the side as well... when he's bad, he's frightening'*. Andrea can '*piss off from him and come back'*. Jack has presented with scratches and Andrea with black eyes. Whilst both have attended for several years, he saw Andrea 18 months ago complaining of stress, the children's behaviour and her difficulty coping. She wanted her usual Serepax. Dr Threadgold suggested counselling, discussed the children's behaviour and parenting issues. She admitted to him she '*flies off the handle'* when Jack doesn't help and can physically attack him- '*yeah, sometimes I'm a real bitch.*' Jack has come in separately and asked Dr Threadgold to give his partner Serepax to calm her down.

> *I can't stand this, she's flying off the handle, she's uptight, give her the pills, Doc, to calm her down, sort of thing. And you can tell that it's a very suppressive sort of approach to it, that if she takes a pill and calms down then everything will be all right.'*

When I ask Dr Threadgold what he thinks the problem is, he replies *'she's not terribly insightful...got a motor mouth, which is thrown into gear before you open the mouth... she just reacts.*' When Jack is not on drugs or booze '*he's a very clever man to talk to and ...has a bit more insight into things when he's got time to relax and think about it'*. He loses his temper, but Dr Threadgold was not sure who's more responsible as once it *'turns violent, they're both into it.*' Dr Threadgold confessed he hasn't made much progress with Andrea and she had gone to see a female doctor at the local CHC.

In the **second** interview, I asked if Andrea's childhood had been abusive or if she had witnessed violence. Dr Threadgold hadn't asked. He consulted her file. She had been coming to the clinic for years and she had had a '*lot of pelvic pain'* and gynaecological problems *'of uncertain cause'...but pelvic pain and irregular periods, .. may well relate to past things.'* He began to consider - *'Its interesting, when you start to talk about it like this, you begin to wonder whether you're missing a whole lot of things.'* He commented that women often come in crisis, on a Monday evening when he has a full waiting room. *'They choose bad times to come...she wants a solution then and there for the next day or so, or she wants me magically to click my fingers and make the whole thing better.'* He settles any acute safety issue and suggests they come to talk at more length later. *'If they don't come, one wonders whether they're motivated to do a great deal about it.'* He thought Andrea was ' *'prepared to put up with the situation, I think she probably gives as good as she gets half the time and that the relationship sort of goes from fight to fight, and in between things sort of calm themselves down'*. He commented that she'd come in with '*a not coping medical thing and you could tell she'd just be over the top. Somewhat manic almost in her approach and you would fairly rapidly get onto what a bastard he was, he's bloody off again and we all got pissed last night and we had a big fight'*.

Dr Threadgold mentioned that their daughter, 14, had been hospitalised with pneumonia and was *'beginning to exhibit Mum's behavior*. He hadn't seen any children before this daughter, as they see different doctors at the clinic. He observed '*You tend to get different doctors looking at different parts of the problem and nobody putting the whole picture together... And in fact it may be manipulative by the patient to purposely not allow [you] to delve into too much detail.'* He wondered if she had told the other GP *'we were all a pack of arseholes and were no good at all or whether we were getting a bit close to some home truths and we [she] want to go elsewhere.'* I asked him what he thought the home truths might be *'you're getting into the details of family violence and maybe sexual abuse of children'* He thought there was every chance the children may be abused. Jack:

Always appears a really nice, easy going sort of bloke and you think, was all this true [what Andrea says] and I suppose they're the ones you've got to be a bit more suspicious of.

In our **fourth** interview, Dr Threadgold had seen Andrea, things had settled down and she came in with an irritable bowel, but on leaving, told him a joke about battered women – *'what do you tell a woman with two black eyes? Nothing, she's been told twice already. Now I thought, oooh, that's a bit sad coming from someone like that'*. He hadn't asked about home, as she looked well and happy and he didn't have the time available at that point.

In the **fifth** case interview, Andrea was back on anti-depressant medication *and 'I think that calms her down a bit. So, she's not as much of a fiery character.'* When I ask Dr Threadgold to reflect about the progress of the relationship as he has observed it, he observed *'I think the quieter Andrea gets, the better the system runs. When she's under control, everything else seems to fit in and go under control'*. Dr Threadgold thought that Jack became a truckie to get away from home. He commented that when he was unemployed, there were more problems when they were both at home together with nothing to do. They had both stopped taking speed and Jack was drinking less. Dr Threadgold thought that they were probably equal in terms of power relationships. He perceived a pattern of Andrea being more verbally aggressive and Jack being *'more broody'* and then eventually he lost his temper. Dr Threadgold thought they were both physically abusive. Glancing at their notes, he noted that Jack had been a patient since 1994 and a doctor noted in 1995, that Jack had a *'domestic last night. Hit various things including the wall. Broken his finger'*. Later that year, someone noted *'problem with temper. Needs anger management.'* Jack had not yet been referred to anger management or behaviour change.

Dr Threadgold believed that relaxation classes at the CHC would not be suitable for working class people, as they didn't need to *'lie on the ground, smell incense and learn how to breathe ...Because these people have no idea. And therefore the problem is overwhelming to them and they just lose their temper.'* Dr Threadgold thought that treatment needed to be more physical. Working class people didn't need *'in the head stuff'* but to be shown more explicitly what to do. I asked whether he saw Andrea on medication as a long-term solution and he explained that he wanted to stabilise things so that they could have a discussion about a long term solution. He describes her not as depressive, but as having *'emotional highs and lows and that's aggravated by ... four children who are all asking you to do things at once and you're not feeling any good. You tend to lose your temper'*. He last saw Andrea in July 97. In Oct 97, Jack was worried about losing his temper and as Andrea was on a lot of medication, she was sleeping a lot. Dr Threadgold thought she had settled down, her skin problems were better and she looked healthier. He had suggested couple counselling but Andrea didn't want to go. Jack was unemployed and with back problems at the moment, but the trucking caused difficulties as well.

In our **sixth and final** interview, Dr Threadgold had seen Jack and Andrea last week and expressed frustration with them. They had separated. Andrea had come in about her asthma and headaches. She had returned to the country for *'a week, because she thought she'd kill the family and she noticed how much happier she was away from the family.'* She told Dr Threadgold that they would all move to the country, but not live together and *'in her words, and all my problems will be solved.'* She wasn't taking tranquillisers.

Postscript: Andrea and Jack remain separated. Andrea lives about 150 km from Melbourne and Jack remains in the urban area. The children see both of them, and the 14 yr old (now 16) was expressing a desire to live with her father whose response was ' you've just had a fight with your mother, haven't you?'. He was correct!

7.2 Dr Errol Threadgold and Fatima

In our **second** interview while referring to his files, Dr Threadgold introduced Fatima, 37, who spoke good English. She was married to a man with a science PhD, who was doing a cleaning job and whose English was not very good. She came to see Dr Threadgold with excema and chronic allergies, as did her daughter, aged 8. I asked Dr Threadgold to recall her first disclosure. He consulted the notes and they went back to 1993.

> *I've got in my notes... on the 12/10/93 she actually came in, saw a different doctor, but 'was allegedly beaten by her husband last night and had a decent bruise on her arm'. In fact it looks like it involved about a third of the upper arm. And there were the odd complaints of headaches and sort of migraine things before that, and a couple of sort of knee injuries. I've known her since 1991. And she actually had a terminated pregnancy and that was the first consultation. Sending her along for a termination.*

He continued reflecting on the notes;

> *There were odd sort of .. .sexual things to do with the contraceptive pill and discharges and bits and pieces, but nothing really particular or specific. Then through 1993, sort of chest pains and rather non-specific musculo-skeletal type things... and then the admission that the arm had come from a beating from her husband. Then we get into 1995. So really, she tended to put up with that for a long period of time, but she was really the one who did everything. We were just ... an occasional complaint house, rather than actually managing anything, she did it all herself.*

In 1995, she disclosed repeated beatings and a dictatorial marriage. Dr Threadgold was surprised to hear this of the husband, but said he believed her. She was desperate, but just wanted to '*talk about it*'. In late 95 or early 96 they moved to Cairns, but Dr Threadgold wasn't sure whether it was to maintain the marriage or help with the allergies. Fatima had hoped things would change, but they didn't, so she had come back and was now living on her own. Dr Threadgold thought he would have given her his standard advice to women who were talking of leaving, to think whether the relationship was worth saving, ensure your safety, have relationship counselling:

> *If things were not working or you decided it was time to get out, to actually go down and talk to Social Security about an income, talk to the Housing Commission about a house, so you didn't sort of leave in an anger state and have nowhere to go. So you had to come back two days later with your tail between your legs. That you sorted it out, went to a lawyer if need be, sorted out your financial, what you could and couldn't do...I've always said that if you walk out in the cold hard light of day you make a decision, you chose your day and you stick to it.*

Dr Threadgold had written a letter for her to Legal Aid that in her dermatologist's opinion her excema got worse under stress, and how often he had given her desensitising injections. He recalled that he saw Fatima's daughter mostly for '*allergy things*', but there were some behavioural things - '*some nightmares and stuff*'. The practice employed a female paediatric consultant who now saw her.

In the **third** interview, Dr Threadgold recounted how Fatima was looking much better. She had found lawyers and won $7500 from Crimes Compensation. However, her husband was fighting over the house. She couldn't sell it for its original value and her husband was buying her share at a low price, paying in very small instalments. Dr Threadgold described his role now as just a sounding board, being supportive and providing referrals if needed. He hadn't checked whether she had support networks as a single woman. He thought a wall of silence and fatalism was a barrier to working with Turkish women and the notion that he had no right to inquire with the men.

In our **fifth** interview, Fatima and her husband remained separated, but Dr Threadgold had seen her in December on a weekend when she insisted her husband had come in together with their daughter to hear about asthma management strategies. Dr Threadgold remarked that he looked

uncomfortable, but thought Fatima wanted him to hear from the doctor and take shared responsibility for their daughter's care.

Postscript: Dr Threadgold wrote that he doesn't see Fatima any more and thinks that she and her husband remain separated and she no longer lives in the area.

7.3 Dr Errol Threadgold , Mr and Mrs Ahmed

In our **fifth** interview, Dr Threadgold introduced Mr Ahmed, his wife, who speaks no English, and their two small children. He had grown up in Australia, but Mrs Ahmed in Turkey. Mr Ahmed had worked in a tyre building business. He had been trying to better himself and took an overtime shift in order to pay off his house. However, twelve months ago, on his first evening, he had a serious car accident resulting in serious chest injury and ongoing pain. He had presented with insomnia, he couldn't talk to his wife and children and couldn't work. Dr Threadgold perceived:

> *After about six weeks he's having a real hard time because he's cross and angry, he's not getting any money, you know, everything's going up the wall. And he has started to drink and smokes dope in order to cope with his problems, and he's losing his temper. His wife doesn't understand it, and eventually after a few physical fights with her and him on both painkillers and anti depressant medication to try and calm him down, a bit of counselling with him ... He, he did attempt a suicide, but he just ended up in casualty overnight, and [was] sent back home again.*

Dr Threadgold involved the mental health crisis team when Mr Ahmed attempted suicide and they gave him Largactil. Following this, apparently Mr Ahmed drank for two hours and sat down in front of a train. After being released from a psychiatric hospital after a few days:

> *Under the transport accident scheme (TAC), we sent him to a psychologist to start with, which he didn't find particularly useful, and he ended up seeing a psychiatrist out at [psychiatric hospital] which he's found more useful for him. And his wife spat the dummy quite a bit after all of this and, well in the early part of this year he wasn't coping particularly well with his temper tantrums and his pain and everything. So she sent him out to the garage to live. He's living in the garage, and he has been living in the garage for about twelve months.*

Dr Threadgold doesn't believe that Mrs Ahmed understands why her husband is behaving this way, his job and financial stresses. He was very controlling and organised, had a detailed financial plan and was paid up five years in advance on his house payments. He was very distressed about losing control.

> *He was really that focussed, and controlling over all of this, that he really didn't cope at all. And she can't cope now with the fact that she's got his husband who's behaving the way he does. And she's getting her brothers to come round to defend their sister.*

Dr Threadgold expressed concern that Mrs Ahmed's brothers were threatening to kill him. He had learnt from the rehabilitation worker that Mr Ahmed's perceptions of his work performance and those of his employer were different and he needed to counsel Mr Ahmed in order to help him to manage the negotiations. Dr Threadgold perceived him as intransigent:

> *He was of the opinion that he's tried really hard at work... and he deserves a bit of a favour from them and that they keep putting him on this machine that causes his shoulder and his neck to ache and he can't work. When you talk to the rehab, they say, you've got to push three buttons on a fairly regular basis, and that pushing buttons certainly might produce a bit of neck ache and pain, but it's not an insurmountable problem. But for him, I think again, a little bit of pain is out of, I can't control it, and it's terrible, it's disastrous, I can't cope with it.*

Dr Threadgold said that the goal was to loosen his personality. He wants to get some trans-cultural therapy for Mrs Ahmed to help her understand Australia, its expectations, education and her children. However noone has the responsibility for seeing that she gets this help. She may simply want a quick divorce. The children, who are kindergarten age want to stay in the garage with Mr Ahmed, he reported. Dr Threadgold thought it was probably very distressing. He thought Mr Ahmed should move out, but didn't want to suggest this. He would like them to have family counselling, but didn't think that Mrs Ahmed would. They didn't use the interpreter system as they did not trust its confidentiality.

At our **final** interview, Dr Threadgold told me that Mr Ahmed had come in with his son. He was still living in the garage and complained about his back. He also mentioned that the son had been suspended for being violent at school.

Postscript: Mr Ahmed remained in the garage, but was beginning to talk about having to resolve the situation - either start to live together or separate.

APPENDIX 2

SUMMARY OF INDIVIDUAL CASES PRESENTING TO CASE DOCTORS

Doctor	Case	Presentation and manner of disclosure	Type of violence reported	Management	Resolution	NESB
1. Dr Harold Rosario	1	The 'Montari' family. Mrs Montari presented in her early 60's with blood pressure, weight problems and arthritis. Gradual disclosure of severe abuse.	Severe physical, sexual and emotional abuse (including threats to kill). Also abused children. One daughter left and married early, another had a promiscuous phase, had STDs and now with abusive male partner. Sons, very 'sheepish, live together, don't fight for their rights'.	Although disapproving, supported her separation and divorce. Saw daughter, also abused and counselled her to leave, although she was not ready.	Woman was progressing and has divorced. Clearly supported to make changes about her physical health. A 'good' victim	Yes
	2	Woman, divorced, presents with children and for blood pressure checks, 'the usual things'	Doctor inquired after training, as he had suspicions of abuse. She confirmed physical abuse, not much detail	Doctor used case to illustrate how women don't mind being asked.	He confirmed his thinking that abused women should separate.	Yes
	3	The 'Mizzis'. They both present with obesity, he with diabetes, she with epilepsy. He also has syndrome X and impotence. He was illiterate and on disability for back pain. Regular attenders.	Marital rape, sexual abuse and physical and emotional abuse of children. Domineering man. His father was dominating also. Although doctor doesn't specify, she must have disclosed to him.	He advises her to consider separation. Counsels more assertiveness. Ordered her copy of Mirrors, Windows and Doors. Tries to raise with man in denial.	Doctor later reports some progress and they leave for holiday together.	Yes

	4	The 'Starellis' Longstanding patients. Couple, husband on a disability pension with cardiac and back problems, in mid-50s, wife works and he disapproves. She has presented with pain and tenderness. Clearly he has spoken to both about abuse.	Earlier jealousy after marriage. Physical and sexual abuse, constant tension. Doctor classifies wife as 'nagger/provoker'. She has called police and man was aware he could be charged with assault.	Doctor has suggested she separate (she is worried about money, given booklet and suggested counselling. Referred man to MRS, bad experience, then to CHC. Man hasn't gone yet. Believes they are 'stuck'	No resolution in this case.	Yes
	5	Woman disclosed level of serious abuse to doctor. Partner presented occasionally as 'nice' but rigid. She had depression and high BP. Vague symptoms, aches and pains.	Described husband as domineering and terrorising with gun under his bed. Doctor unsure if it was physical, certainly psychological and verbal.	Encouraged her to leave and she did. Possibly suggested solicitor. Doctor suggests that where she looked old, she now looks young.	She left and now she was both healthy and happy, according to doctor.	Yes
	6	Patient of 6/7 yrs. Woman with severe migraines who finally disclosed child rape/incest from father and whose father moved close by (elder of church) and wanted sex from her in late 50s. Happily married.	Childhood sexual abuse and now recurrent demands.	Had treated her with pethidine injections. Now offers support and belief to her. Again gave her Women and violence booklet.	Ongoing	Yes

2. Dr Errol Threadgold	7	Andrea &Jack, mid 30s, long-term clinic patients seen Dr 18 mths. She presents with depression and anxiety. Truckie husband - passive aggressive. Attend separately and together. Man abuses alcohol and drugs- Needs anger management. She has history of unresolved pelvic pain, gynaecological problems, IBS. 14 yr. old daughter with pneumonia. Man has smoking related issues, hand injuries and scratches.	Dr perceives both abusive. She fights back, drinks, is assertive and may leave at times. Believes he doesn't help with children. Physical abuse. Dr raises possibility of CSA. She tries to escape to Sydney and was raped. Doesn't report to police. Dr describes relationship as violence, aggression and love.	Couple have seen many doctors at clinic, but case not coordinated. Dr doesn't say he has tried anything with man other than time out, but has medicated (tranquillised) woman.	She separates and goes back to Mum so she doesn't kill them all. Wants to live separately.	No
	8	Similar couple to above in their 30s. Have six children-one was 'magnet for problems'. Both mother and daughter have babies. She is reported as violent with sister and feisty. Husband passive/aggressive and drinks, ignores problems. Man has arthritis.	Unsure if there was any physical violence in this relationship or if Dr was suggesting it was from her. Certainly CSV involved and suggestion that children were abused. One child severely disturbed.	Dr reports talking down crises and getting man off grog. Counselling.	Couple separated. See each other several times a week.	No
	9	Woman with de facto partner Aust born NESB workers' compensation case, during which he was sacked, house repossessed. Dr sees couple. Man abuses medication and also takes speed. Dr aware he should be concerned about children.	Physical abuse - woman wants to maintain relationship but man to change. Man noted in file as 'lazy, violent, poor judgment with children'.	Dr dealing with workers' compensation issues, tried to raise violence, man denies problem with violence and medication. Dr gives Serepax to woman.	No resolution. Problem ongoing.	Yes

	10	The Ahmeds. Aust. born Turkish man, wife from Turkey, car accident twelve months ago. Bad pain, drinking, smoking dope, suicidal and violent with wife. Insomnia. Family members translate - not clear who. Kindy age children. Son suspended for violence at school.	Physical abuse of wife. Wife sends brothers to threaten to kill him and bans him to garage. Man very controlling with low frustration level.	Painkillers, anti-depressants and counselling- then called in crisis team when man is suicidal. Given Largactyl. Ongoing case.	No resolution. Situation in flux. Man still in garage.	Yes
	11	'Fatima', 30s, presented with chronic excema and allergies, daughter for nightmares and bedwetting. Husband rarely attended, PhD but cleaning. Good English. Attended many years. Disclosed in desperation. 1991 TOP. First disclosed in 93! Headaches, migraines, injuries, discharges etc	Chronic physical violence and controlling behaviour. Probably sexual abuse also.	She managed everything. Repeatedly presented, disclosed in 93. Nothing done. Doctor may have advised her to plan leaving. Gave her reports for Legal Aid. Sent daughter 8/9 to psychologist.	She has left husband, sold house to him for low price and was improving.	Yes
	12	Boilermaker businessman who came once. Presented with problems and story of drinking. D&A counsellor wife had intervention order banning him from drinking. Minimisation of abuse.	Man possibly violent after binge drinking. Wife frightened enough to call police and take him to court to ban alcohol near premises.	Doctor counselled him and tried to get him to accept some responsibility, but he hadn't returned as yet	No change	No
	13	Part-Aboriginal woman with Italian husband who left her with child, now behavioural problem at school. Presented with coping problems.	Certainly humiliation, harassment and emotional abuse. Not sure of any other.	Offered support and a 'sounding board'. Took part in case conference at kindergarten.	Ongoing.	Koori

	14	'Helen' nurse 50, with alcoholic, abusive partner of 20 yrs. He had acute renal failure and was hospitalised. Took himself off 'grog' and 'smokes'.	Chronic physical violence associated with his drinking. All children left home. She had 'jokingly' threatened to kill him one day.	Doctor currently counselling her in her nursing role and reinforcing man's dependent status. Hasn't challenged his ability to give up addictive behaviours.	Ongoing - currently she is continuing her nursing role at home	No
	15	Intellectually disabled young rural woman brought to CHC by partner with serious facial injuries. She discloses after doctor queries explanation.	Physical violence not a one off event according to workers. Woman has small child.	Doctor liaises with workers who assure him they will take it up.	Uncertain	No
3. Dr Peter Greenway	16	'Amanda', 40s has alcohol problem and has known doctor socially for many years. Doctor asked her about abuse, revealed gross CSA. Children presented with asthma etc. Husband with psoriasis.	Dr reports both hitting and yelling. One son, poor school performance, charged with stealing car parts. Dr claims all finished when she disclosed and forgave father.	He established motivational counselling directed to forgiving father. She says it has been useful.	Long-term outcome? Poor relationship with mother who doesn't want abuse aired.	No
	17	Severely abused woman comes to Dr. She had presented with severe injuries couple ascribed to car crash. Later presented with injuries and then left man. Obvious case Treats parents for anxiety-related conditions.	Severe combined abuse by criminal partner who threatens to kill woman. Two small children. Partner released from jail. Beat her up, she left to live with parents, but may have returned.	Doctor has urged her to leave and referred her to lawyers to obtain Intervention Order. Police involved. 'Way out of my league'	Ongoing, Unclear if she was separated at present. Has 'slipped through the net'.	No
	18	'Sophia' 17 yo girl GP asked after undiagnosed conditions-headaches, stomach pain etc. Disclosed 'mild' sex abuse from NESB grandfather. Angry father came in only for counselling session.	Single case of touching genitalia, however father threatened physical abuse and mother left, charging him with violence and instigated IO.	Dr's approach was family maintenance and asked to ignore Intervention Order to bring father and daughter together.	Reconciliation unsuccessful in longer term.	No

	19	Girl with symptoms suggesting CSA. GP knew her since eight. Challenged her and she disclosed.	Severe CSA.	Dr believed and supported her. Father was subpoenad to appear in court.	Case has gone to court	Do not know
	20	The 'Greens'. Couple who had been to Dr for ten yrs. He presented for workers' compensation issues related to back and depression, then presented with self-mutilation. She had ongoing diabetes and chronic migraines	Unclear to GP but assaulted neighbour, stalked and terrorised wife with guns, financial abuse - most probably combined abuse. Two children 7 and 10. Dr more tuned to CSA, definition of DV narrow.	Doctor has treated both for physical problems, - aware of financial and verbal abuse - no referrals. Unsuccessful counselling with man.	Ongoing.	Do not know
4. Dr Jane Norton	21	Mrs Davis first presented with daughter, BP exam brought bruises in view, woman disclosed cyclical violence when manic-depressive partner off medication. Major focus for her, bulimia and weight 'lynchpin of the family'. Dr feels ineffectual.	Woman raped by ex-boyfriend. Intermittent physical violence from psych. ill husband. Financial abuse and total dependency. She does all work, employed also. Parents only support if she stays. Concerned abt impact on children, would leave if not for children.	Dr panicked initially - supports woman, treats symptoms, counsels her. Cannot coordinate with GP partner who treats husband. No stated practical advice when woman wants to leave -	Women concerned when partner goes off medication coming again. Ongoing.	NESB ?
	22	Young man, 22, presented with injured right hand hitting corrugated iron, slurred speech, drink-driving accident, worried about anger -(girl-friend mandated). Baby not his.	Potential if not actual physical assault. Certainly impulse and anger control.	Dr applauds his move, gives him referral to male counsellor, orders X-ray and asks him to return but he doesn't.	Do not know	No
	23	Older woman, late 60s. Chronic schizophrenic, broken arm from push by son two days previously.	'Mild elder abuse' by son. Dr seems to agree with family this was difficult and no cause for concern, as they needed to restrain her.	Dr treated arm and wrote letter to GP.	Do not know	Do not know

	24	Depressed man whose ex-de facto partner had taken baby. He had hired detective as he was worried about 'drug bust'. Control issue.	Unclear 'violence' and relinquishing control. He has two other counsellors	Dr treats depression and offers a lot of support. Doesn't discuss dealing with violence.	Not applicable	Do not know
	25	Mrs Evans presented with bruises five days after assault by partner. Was pregnant and wanted TOP. Also wanted treatment for partners anger, didn't want to leave. Couldn't open eyes and sorely bruised, possible concussion	Physical violence on three stated occasions, usually with pregnancy. Children witnessed. 5 and 10 months.	Dr documented injuries and cause, referred her to men's program. Diagnosed pregnancy and asked her to return for TOP. Saw some-one else next day and didn't return.	Referral to appropriate services	No
	26	Mr Connor, very depressed, frustrated self-mutilating and suicidal man with 14 yo son. Ex-partner has other two children. Been in jail. Presented with low back pain and depression, financially deprived.	Unclear, possible violence, but only reported threats to self-harm and very alienated ex-partner. Police had been involved in stand-off with guns in former house. Threats of suicide taken seriously by doctor.	Unconditional support through critical suicidal period. ADVocated for his superannuation with specialist. Unable to discuss needs of son.	Man received entitlements and got over suicidal period. Son remains at risk.	No
5. Dr Jill McPherson	27	Maltese couple, ongoing pts, good rapport with GP, who treated for stress, anxiety and depression. Woman disclosed abuse when she queried bruising. Attempted to engage man, w/o asking woman with disastrous consequences.	Man intermittently physically abusive to wife. Unclear about the other. May be combined abuse. He had been pressuring her to leave son and return to Malta - control? Emotional abuse of child?	Dr cites this mistaken approach as a lesson to her. Tried to broach violence when he raised anger. She believes desire to foster good relationship a trap also.	Poor outcome as she lost both patients.	Yes

	28	Long term patient. 27 yo woman, factory worker, assertive veneer, sevcre maternal abuse as child (and DV?) and abusive partner, late 30s and children. Raised her own abuse of children, partner angry at involvement of CSV. He blames her, very controlling. Children 5 and 18mths. Both drug abusers.	He was certainly physically and psychologically abusive to woman, not to children. She runs away. She accepts blame for his violence - her fault. She normalised his violence. He claims he knows its unacceptable now.	Initially control of man's anger, psych referral for woman, who was treated for depression, drug abuse and anti-social traits. Dr attempts to teach her man's violence unacceptable. Supports man when woman left. Child referred to CSV, locates child's sources of support. Monitoring family.	Ongoing, but critical point well dealt with and family has support - although man no formal treatment of his abuse.	No
	29	Young woman, 20s, separated from boyfriend because of psychological abuse, disclosed after Dr asked following training. Abuse also involved some pushing etc. Presented for antenatal care.	Quite serious emotional abuse, although doctor believes pushing and shoving may have been 'mutual' - she retaliated. He returned when she was later pregnant.	Dr supported and listened. Cautioned her about demands of baby.	Serious psychotic illness	Do not know
	30	Part Koori young man presented with anger problems. Depression. She also sees other members of large extended family whom she has referred to TAFEs. Mother she claims Munchausen by proxy also experienced violence	Physical abuse, other? Dr believes violence a norm in the family.	Dr was using TAFE as empowerment medium for family. Offered young man counselling and referral but he has yet to return.	Ongoing	Koori
	31	Male victim and Filipino wife. He presented with depression.	Claimed physical and emotional abuse	Referred to social worker for counselling.	Appropriate referral.	No

	32	'Yusufs'. Kurdish man and illiterate popular wife. He presented for back problems, and had disastrous workers' compensation case in which they lost house. Following this, he under went back surgery, and reactive depression. Wife told doctor of his two abusive physical episodes during depression. She would not tolerate as she was badly abused as child.	Two times physical slapping and some psychological abuse. Wife used her strong friendship network and standing in community to shame man.	She successfully assisted him to win workers' compensation following failure, treated depression, taught control strategies, supported wife in asserting violence not to be tolerated. Hoped to help wife gain work via TAFE.	Wife supported, man agrees to change. Ongoing.	Yes
	33	Australian-born Eastern European woman child witness presented via social worker and disclosed without prompting. Sent by social worker. Had to leave refuge and inappropriate housing and return to live with ex-partner's Yugoslav family, now abusing her and using 7 yo daughter as well.	Systematic emotional " multi-level abuse' according to doctor. Physical abuse previously.	Social worker asked doctor to record physical outcomes of abuse and help woman to get housing. Advocated for woman and currently attempting to find her proper, safe housing.	Woman was supported but still vulnerable.	Yes
	34	33yo bikie presented eight years ago with chronic and severe physical and sexual abuse by ex partner and young son. Son exhibiting behavioural problems at school 'a bit of a brat'. Woman disclosed violence etc	Very severe combined abuse, rapes assault and stalking.	Woman asked her to record bruising etc. Had been raped prior to seeing doctor but had been explicit about these and had service help, refuges etc	Man had ceased stalking her and she comes less frequently	No

6. Dr Rosalie McLeish	35	30 year-old woman with multiple problems, victim presented with sleep disturbances, alcohol and tranquilliser addictions and marital conflict in which she was abusing. Dr found her very difficult, had seen many professionals.	Woman had experienced rape nine months ago. Clearly earlier issues not referred to, but doctor thinks she was abusing husband. Not clear how - suggests CSA.	Dr managed to get her alcohol under control, tried counselling, felt un-focussed in it, but felt woman difficult person and eventually referred her on.	Woman's alcohol abuse diminished but needs passed on.	No
	36	Woman presented 18 months ago with routine gynaecological check-up. She recently presented because she was stressed at work, but disclosed former depression after previous abusive relationship	Previous domestic abuse - unspecified what level.	Dr gave her work certificate to have time out and planning short and long-term goals. Helped her to leave job. Seeing her monthly. Described process as ventilating and allowing her to see how much she gives others and not herself.	Doctor felt she was doing very well.	No
	37	Another woman in isolated rural area, came one and half yrs ago for cancer and then recently for depression. After doctor questioned her about life history, found she had experienced very abusive relationship	Serious chronic abuse. Only sees partner in relation to children	Although doctor offered support, a few options for counselling, woman wanted depression treated medically.	Unsure	No
	38	19 yo woman treated antenatally, GP finds partner psych abuser. She left partner and then returned and became pregnant second time.	Verbal and emotional abuse.	Referred to Grey Sisters and works on self esteem issues.. They self refer to couple counselling.	Improved after couple counselling. GP lost touch.	No

	39	'Rose and Jethro'. Couple in their early 40s, unemployed, referred by counsellor for depression and 'mutual violence?' Partner claims she may hurt him or both and wants her referred	Emotional abuse- she's crazy. Both shout and throw things. Dr thinks they are equally powerful, but he owns house and she has no space.	Refers partner to someone else and focuses on woman. Sees woman progressively less frequently.	Woman has own room and more effective communication	No
	40	Older woman in her 60s who has been in abusive relationship for many years. After three years, woman broke down one day and after questioning, disclosed.	Severe chronic abuse - no detail, but described as 'creepy and disgusting' probably more sexual.	Empowerment strategies to help woman survive as not strong enough to leave. Reinforces her worth as a person -helps her find separate life. Arranges social worker to assist when both in hospital	Ongoing but woman validated and supported	No
	41	Woman in 50s, isolated, presented for chronic unspecified medical condition. She was financially, socially etc imprisoned and abused. Again woman disclosed when questions revealed how little money she had.	Controlling partner, who uses financial abuse and isolation with wife. Dr worried about escalating abuse as woman was more assertive.	Dr refers her to lawyer and some financial counselling Arranges all information and documents to come to surgery where woman can pick them up.	Court case finds in her favour.	No
	42	Woman, 35, presented with serious depression, insomnia and acute anxiety triggered by daughter who had disclosed abuse by grandfather to boyfriend who told her. Memories of father's abuse. Left abusive relationship with drug addict	Serious CSA, flashbacks due to daughters abuse and previous domestic abuse-unclear level. 17 yo daughter abused by grandfather	Dr McL treats her depression and offers her hope and support, commends her bravery. Sees her several times a week during critical period.	Ongoing - woman didn't want to deal with issues yet.	No

7. Dr Sally Morris	43	Woman, 30s, previously presents with children, disclosed husband had hit recently and it was very intermittent, annually - describes herself as assertive/dominating	Intermittent abuse - husband says she was verbally abusive. (Wants own rights?)	Doctor offers referral for man to program but suggests marital counselling. Dr felt woman didn't accept own need.	Woman did not return.	Do not know
	44	Woman with young children presented frequently, when asked, disclosed emotional abuse, but had decided to separate and was happy with decision	Emotional abuse. Concerned about impact on children	Doctor offer her support and suggests separation counselling and child psych support	Woman has support to separate and other options if she chooses.	Do not know
	45	'Mrs Pickett'.Woman with 16 yo son with 20 yrs abuse. Disclosed abuse and came every few months. Had previous breakdown and attended tranquilliser group for addictions. Low self-esteem, abused at work, but eventually left work and left husband. Returned with high BP and possible eating disorder - organised self-help GP.	Husband very abusive, throws away medications, son unsupportive. When in hospital husband woos- cyclical violence. Left husband but returned after wooing, left finally.	Doctor offers financial, counselling, many options for woman. Helps her to leave, but concerned for her when woman doesn't take up tests for damage to colon and high BP.	Ongoing and slow recovery. Woman chooses support intermittently. Relationship with son improving.	No

	46	'The Nicholls' Couple seeing registrar, whom doctor teaches. Both from alcoholic domestically violent families, she had violent ex-partner. Two children ten and twelve. Man disclosed to registrar, woman disclosed to GP when she asked about her coping - woman broke down.	Man was abusive when drunk, but wants to change and woman wants to help him.	Dr advised referral to CHC program. Both attending. Offered woman help and identified her problems. Modelled empowerment counselling using family of origin issues.	Family moved with registrar. Progress but a long way to go.	Do not know
	47	'Mrs King' Woman from abusive background, also been raped by stranger. Phobic and under-confident. Children with special needs (unspecified) Also sexual problems which were resolved	Although current partner supportive and non-violent, father had been abusive, both physically and psychologically. She had been raped in a car and was phobic about cars and phones.	Doctor had empowered and counselled her so she overcame car phobias and felt enabled to chair committee. Also provided some sexual counselling.	Woman made good progress.	No
	48	Woman from family with alcohol abuse and violence had abusive partner, but partner had absconded with sister a year before. Woman presented with depression, insomnia etc. Woman also discussed problems with six yo daughter.	Family of origin had violence and mother addicted to alcohol, she was probably abused (unclear). Her abusive partner had left her for sister and was financially abusing her. She had difficulties with daughter and husband.	Doctor had provided sounding board for her and some treatment for depression, but woman had not returned after holidays.	Ongoing, unsure	No
	49	New case of woman with fading black eye, victim of multiple chronic abuse. Had seen many doctors in clinic who had tried to persuade her to leave. Doctor tries to talk about it, woman says she's leaving and knows what to do	Severe chronic combined abuse	Doctor raises issue, woman didn't want to discuss. Dr feels frustrated as unsure if woman will leave.	Uncertain, possibly no change	Do not know

Other cases	50	Woman and yr 12 daughter present in crisis. Father threatened both mother and daughter. Had decided to flee. Later daughter returns, mother back with father and daughter feels very unsafe.	Severe chronic combined abuse	Doctor reviews safety plans and pleased they would leave. Now concerned for daughter	Unsafe	Do not know
	51	Woman presented fearing for life, heavy bruising on upper torso and arms, almost slavery. GP had been woman's antenatal doctor. Child 18 months.	Severe chronic abuse and potential danger to child	Doctor tried but failed to persuade the woman to leave and doctor very concerned	Unsafe	Do not know
	52	Man, truckie, physically abused as child, presents with depression and problems - road rage, violence, abuse. Lives with woman and her teenage children and she excuses behaviour as ADD.	Violent to animals, hit horse, threatened suicide, verbally abusive to wife and her children, 'narcissistic', blames others	GP doesn't accept his blame story, counsels and refers him, treats depression and supports wife separately and doesn't accept her excuses for him.	Ongoing	Do not know
	53	Woman victim of CSA and former abusive relationship, had A&D addiction. Had organised a lot of support for herself. Used doctor to help maintain her limits	Victim of CSA from grandfather and had experienced abusive relationship she had left. Self-abuse	GP describes woman's initiative - she used GP for debriefing and support. Self referred to domestic violence agencies.	Progress	Do not know
	54	Woman disclosed abuse when pregnant from employer partner, now has child. Man violent to former wife and children. Children had witnessed abuse.	Financial and physical abuse, serial abuser, woman feels financially and emotionally dependent.	GP presents case to network and learns of advice and new perspectives	Unsure	Do not know

	55	Woman asks for tranquillisers, doctor asks why. Abusive partner will be at daughters deb party and she needs support to cope. Man was still controlling and violent to property and she feels a 'wimp'	Man very abusive and controlling. Hasn't beaten her for a while but still smashes walls and property.	GP provides support.	New, but ongoing	

APPENDIX 3

CODING FRAMEWORK

Q.S.R. NUD.IST Power version, revision 4.0.

Licensee: NCEPH.

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(4 2 3) /Case data/Dr Errol Threadgold/Lebanese couple
(4 2 4) /Case data/Dr Errol Threadgold/Fatima
(4 2 5) /Case data/Dr Errol Threadgold/Ms Kylie Baggins
(4 2 6) /Case data/Dr Errol Threadgold/Robby and Noelene Brady
(4 2 7) /Case data/Dr Errol Threadgold/Mrs Helen Duckett
(4 2 8) /Case data/Dr Errol Threadgold/Factory manager
(4 2 9) /Case data/Dr Errol Threadgold/ Tanya and Serge Dragovic
(4 2 10) /Case data/Dr Errol Threadgold/Intell. disabled girl
(4 2 11) /Case data/Dr Errol Threadgold/Koori family
(4 2 12) /Case data/Dr Errol Threadgold/Mr and Mrs Ahmed
(4 3) /Case data/Dr Peter Greenway
(4 3 1) /Case data/Dr Peter Greenway/Joanna
(4 3 2) /Case data/Dr Peter Greenway/Amanda
(4 3 3) /Case data/Dr Peter Greenway/Raewyn
(4 3 4) /Case data/Dr Peter Greenway/Sophia
(4 3 5) /Case data/Dr Peter Greenway/Anna K
(4 3 6) /Case data/Dr Peter Greenway/Mr and Mrs Green
(4 4) /Case data/Dr Jane Norton
(4 4 1) /Case data/Dr Jane Norton/Mrs Davis
(4 4 2) /Case data/Dr Jane Norton/Mr Bradley N
(4 4 3) /Case data/Dr Jane Norton/elder abuse
(4 4 4) /Case data/Dr Jane Norton/Mr Steve S
(4 4 5) /Case data/Dr Jane Norton/Couple V
(4 4 6) /Case data/Dr Jane Norton/Mrs Evans
(4 4 7) /Case data/Dr Jane Norton/Mr Connor
(4 5) /Case data/Dr Jill McPherson
(4 5 1) /Case data/Dr Jill McPherson/Maltese couple
(4 5 2) /Case data/Dr Jill McPherson/Ms Murray
(4 5 3) /Case data/Dr Jill McPherson/Katie G
(4 5 4) /Case data/Dr Jill McPherson/Young Koori man
(4 5 4 1) /Case data/Dr Jill McPherson/Young Koori man/Koori mum
(4 5 5) /Case data/Dr Jill McPherson/Mrs Hamam
(4 5 6) /Case data/Dr Jill McPherson/Mr. Taggart with Filipino wife
(4 5 7) /Case data/Dr Jill McPherson/Corrie the bikie
(4 5 8) /Case data/Dr Jill McPherson/Roslyn, Bill and Jenny Bates
(4 5 9) /Case data/Dr Jill McPherson/Mr and Mrs Yusuf
(4 5 10) /Case data/Dr Jill McPherson/Susan Vagovic and family
(4 6) /Case data/Dr Rosalie McLeish
(4 6 1) /Case data/Dr Rosalie McLeish/Ms Tamara C
(4 6 2) /Case data/Dr Rosalie McLeish/Ms Libby J
(4 6 3) /Case data/Dr Rosalie McLeish/Mrs Farmer
(4 6 4) /Case data/Dr Rosalie McLeish/Kate Hanson
(4 6 5) /Case data/Dr Rosalie McLeish/Rose and Jethro
(4 6 6) /Case data/Dr Rosalie McLeish/Alma Matthews
(4 6 7) /Case data/Dr Rosalie McLeish/Mrs Stephenson
(4 6 8) /Case data/Dr Rosalie McLeish/Mrs Robinson

(4 6 9) /Case data/Dr Rosalie McLeish/Matilda Atchison
(4 6 10) /Case data/Dr Rosalie McLeish/Ms Renfrew
(4 7) /Case data/Dr Sally Morris
(4 7 1) /Case data/Dr Sally Morris/Mrs Galloway
(4 7 2) /Case data/Dr Sally Morris/Mrs McIlwaine
(4 7 3) /Case data/Dr Sally Morris/Mrs Pickett
(4 7 4) /Case data/Dr Sally Morris/Sarah M
(4 7 5) /Case data/Dr Sally Morris/Mr and Mrs Nicholls
(4 7 6) /Case data/Dr Sally Morris/Mrs King
(4 7 7) /Case data/Dr Sally Morris/Ms Roberts
(4 7 8) /Case data/Dr Sally Morris/Mrs Batterham
(4 8) /Case data/other cases
(4 8 1) /Case data/other cases/TEMP
(4 9) /Case data/Vietnamese communities
(4 10) /Case data/Turkish communities
(4 11) /Case data/Arabic-speaking Muslim communities
(4 12) /Case data/Maltese communities
(4 13) /Case data/Koori people
(5) /Family practice
(5 2) /Family practice/Percptns of DV
(5 2 5) /Family practice/Percptns of DV/minimisation
(5 3) /Family practice/Working with women
(5 3 1) /Family practice/Working with women/pregnancy and shared care
(5 3 2) /Family practice/Working with women/victim initiative
(5 3 3) /Family practice/Working with women/empowerment
(5 3 4) /Family practice/Working with women/female presentations
(5 3 6) /Family practice/Working with women/parenting
(5 3 7) /Family practice/Working with women/strategies with women
(5 3 8) /Family practice/Working with women/victim perceptions
(5 4) /Family practice/Working with men
(5 4 1) /Family practice/Working with men /male health problems
(5 4 2) /Family practice/Working with men /collusion
(5 4 3) /Family practice/Working with men /masculinity theories
(5 4 4) /Family practice/Working with men /male presentations
(5 4 5) /Family practice/Working with men /male management
(5 4 6) /Family practice/Working with men /men's disclosure
(5 4 7) /Family practice/Working with men /male health behaviours
(5 4 8) /Family practice/Working with men /men and family
(5 4 9) /Family practice/Working with men /men's attitudes to doctors
(5 4 10) /Family practice/Working with men /perpetrator perceptions
(5 5) /Family practice/Children
(5 5 1) /Family practice/Children/child management
(5 5 2) /Family practice/Children/barriers to identification.
(5 5 3) /Family practice/Children/child attitudes and experiences
(5 5 4) /Family practice/Children/violence effects
(5 5 5) /Family practice/Children/parents perceptions
(5 7) /Family practice/Working with couples
(5 7 1) /Family practice/Working with couples/couple perceptions
(5 8) /Family practice/Working with family
(6) /general practice issues
(6 1) /general practice issues/Practice coordination
(6 2) /general practice issues/disclosure
(6 2 1) /general practice issues/disclosure/disclosure and time
(6 2 3) /general practice issues/disclosure/confidentiality
(6 3) /general practice issues/patient/doctor communication
(6 4) /general practice issues/Practice perceptions
(6 4 1) /general practice issues/Practice perceptions/prevalence

(6 4 2) /general practice issues/Practice perceptions/Identification
(6 5) /general practice issues/GP safety
(6 6) /general practice issues/GP role or medical professionalism
(6 7) /general practice issues/GP financing
(6 8) /general practice issues/counselling
(6 8 1) /general practice issues/counselling/counselling training
(6 9) /general practice issues/GP stress
(6 9 1) /general practice issues/GP stress /stress exp
(6 9 2) /general practice issues/GP stress /coping strats
(6 10) /general practice issues/trust
(6 11) /general practice issues/confidence
(6 11 1) /general practice issues/confidence/under-confidence
(6 12) /general practice issues/difficulties
(6 12 1) /general practice issues/difficulties/frustrations
(6 12 2) /general practice issues/difficulties/can of worms
(6 12 3) /general practice issues/difficulties/heart-sink
(6 12 4) /general practice issues/difficulties/difficulties with time
(6 13) /general practice issues/patient population
(6 14) /general practice issues/court and legal issues
(8) /issues
(8 1) /issues/working with difference
(8 1 1) /issues/working with difference/cultural diversity
(8 1 1 1) /issues/working with difference/cultural diversity/diversity within communities
(8 1 1 2) /issues/working with difference/cultural diversity/system understandings
(8 1 1 3) /issues/working with difference/cultural diversity/interpreting
(8 1 1 4) /issues/working with difference/cultural diversity/cultural barriers
(8 1 2) /issues/working with difference/gender issues
(8 1 2 1) /issues/working with difference/gender issues/gender preferences of patients
(8 1 2 2) /issues/working with difference/gender issues/gendered practice issues
(8 1 3) /issues/working with difference/class and socio-economic status
(8 1 4) /issues/working with difference/differences between doctors
(8 2) /issues/research issues
(8 3) /issues/ethics
(50) /temp
(D) //Document Annotations
(F) //Free Nodes
(F 2) //Free Nodes/power
(T) //Text Searches
(T 1) //Text Searches/TextSearch
(T 2) //Text Searches/TextSearch193
(T 3) //Text Searches/TextSearch194
(T 4) //Text Searches/TextSearch196
(I) //Index Searches
(I 1) //Index Searches/pre*post identifcn
Matrix Node.
(I 2) //Index Searches/pre&post-training strategies with women
Matrix Node.
(I 3) //Index Searches/male health problems by men
(I 4) //Index Searches/male health problems by DV worker
(I 5) //Index Searches/prevalence by gender
Matrix Node.
(I 6) //Index Searches/male health problems by case
(I 7) //Index Searches/GP difficulties
(I 8) //Index Searches/prevalence by location
Matrix Node.
(I 9) //Index Searches/abuser education by DV worker
(I 10) //Index Searches/case studies collect

(I 11) //Index Searches/abuser education in cases
(I 12) //Index Searches/men's health behaviour not problems
(I 13) //Index Searches/women's education goals
(I 14) //Index Searches/men's education goals
(I 15) //Index Searches/difficulties by gender
Matrix Node.
(I 16) //Index Searches/couple working by gender
Matrix Node.
(I 17) //Index Searches/violence perceptions by gender
Matrix Node.
(I 18) //Index Searches/victim perceptions by gender
Matrix Node.
(I 19) //Index Searches/couple working by location
Matrix Node.
(I 20) //Index Searches/family working by location
Matrix Node.
(I 21) //Index Searches/family working by gender
Matrix Node.
(I 22) //Index Searches/minimisation by gender
Matrix Node.
(I 23) //Index Searches/female presentation by location
Matrix Node.
(I 24) //Index Searches/male presentation by location
Matrix Node.
(I 25) //Index Searches/perpetrator perceptions by gender
Matrix Node.
(I 26) //Index Searches/couple perceptions by gender
Matrix Node.
(I 27) //Index Searches/Index Search
(I 28) //Index Searches/Index Search193
(I 29) //Index Searches/Index Search194
Matrix Node.
(I 30) //Index Searches/Index Search196
(C) //Node Clipboard - 'Index Search'

APPENDIX 4

FINAL REPORT: RURAL DIVISION DOMESTIC VIOLENCE AND SEXUAL ABUSE PROJECT

EVALUATION REPORT

D. Project Impact:

Evaluation methods

This process and impact evaluation has been conducted using the following methods:

a pre-training questionnaire which elicited respondent GPs' rationale for training and their perceived needs for knowledge and skills development. Summarised information was then fed into the project's developmental process for consideration by the project reference group in their planning process;

- project reference group members were interviewed using a reflective focus group interview at their final meeting; and
- the pre- and post-training Knowledge, Attitude and Practice (KAP) questionnaire survey;
- sessional evaluation forms; and
- a postal survey of the entire divisional membership to assess the usefulness of the service map.

It was decided that a postal survey of all GPs would be more effective than the proposed random telephone survey, because to stratify and randomise the small numbers in the division would provide less valid data. Too few GPs returned the monitoring forms, on which they were requested to keep figures on new identifications. GPs estimated any increases in their identification rates in the post-questionnaire. These figures are reported below.

Note: As the participants in this project were self-selecting and do not represent a random sample of the division's members, the reader cannot generalise from these findings to the broader divisional membership. In addition, eleven GPs completed both arms of the KAP survey, and therefore changes reported in the tables are only valid for these eleven doctors. The percentages reported for all participants in the tables refer to the 15 respondents to the first and 17 respondents to the second questionnaire. While these figures include the eleven GPs in their total, the two groups are not all the same doctors. Ten GPs answered only one questionnaire.

10. The extent of participation by the target group.

The target group was defined as rural GPs and their communities, as well as specialist health and welfare providers in the broader primary care community.

10.1 Attendance at upskilling and networking sessions

GP participants:

Between 11 to 25 (an average of 16 GPs), GP members of the division attended the upskilling sessions provided by the project. This average represents 11% of the entire divisional membership (142). A total of 39 GPs (excluding the GP project manager who attended all) participated in at least one of the various cross-skilling and networking meetings held in the different areas of the division, which is 27% of the entire membership.

Specialist service providers:

The involvement of outside agencies in the project was also excellent. It reflects the desire of other community-based primary care organisations to collaborate with GP divisions. A total of 68 specialist providers, eg, domestic violence female support workers, community police, child protection, Kidshelpline, and male behaviour change program workers attended the various network meetings. They generally outnumbered GP participants by at least two to one. This provided ample opportunities to explain and illustrate their role in collaborative care to GPs and for GPs to familiarise themselves with community based workers and their agencies.

10.2 GP pre- and post-training survey participants:

19 pre-training questionnaires were distributed by the project officer to commencing participants. 15 GPs responded to the pre-training questionnaire, a 79% response rate. These GPs had a mean age of 43 years. There were nine female GPs, all part-time and five males, all full-time. Ten participants work in large practices (4 or more GPs), three in moderate-sized practices (under 4) and one was a solo practitioner.

21 GPs were provided with post-training questionnaires. 17 responded (81% response rate), but of these, eleven had completed the pre-questionnaire. Overall, 21 participants completed one or other of the questionnaires. Of these, ten were male and eleven, female. As there are 142 GPs in the division and only 39 of these are female, female participation in the project represented 28% of the overall female membership, whereas the 10 males represent 10% of the 103 men. The average age of the men was slightly higher at 48, than the women at 41.

However, the eleven respondents to both surveys (five men and six women) were slightly younger - men averaged 46 and women 39 years old. One female post-training respondent, who attended seven sessions was not a GP, but hospital based, so her response was not included in any analysis of the survey, which would bring participation to 22.

Of the eleven GPs who responded to both pre- and post-training questionnaires, eight attended the Forensic Medicine session; seven attended Child Survivors of Domestic Violence and Sexual Abuse, and Child Protection and Community Policing sessions; six attended Vicarious Trauma, five attended the Launch and From Victims to Survivor sessions, four the RACGP Women and Violence, Men who use Violence and Abuse and Crisis Counselling sessions; and three attended Responding to Sexual Abuse (past and present). It is useful to bear this in mind, ie less than half attended the domestic violence sessions, when considering the reported impacts.

11 The extent to which the project achieved its objectives:

11.1 The development and distribution of the service map.

The service map was developed and distributed to all 142 members of the division, both participants and non-participants. Seven different service maps gave information about referral services relevant to the seven different areas in which the network meetings were held. Feedback about the usefulness of the map was collected from two sources and asked GPs to use the following scales to rate the usefulness of the maps.

1 very useful...2 quite useful....3 unsure re usefulness...4 not very useful...5 not at all useful

Feedback from respondents to the post-training survey:

Almost all GPs rated the map as very useful or useful.

Of six S. GPs, two rated it 1, three gave it 2 and one 4. One respondent had lost it!

Of the four W./K., L., R. GPs, two gave it 1, one 1-2, and one gave it 2. The one M./B. M.GP gave the map 2. One C.GP gave it 1, commenting that

'It would be very useful to many. I was aware of most of the services, except Kidshelpline, which is a great re

2. A postal survey of the divisional membership

Only 23 GPs replied to the postal survey, a response rate of 16%. As participants had given feedback about the map in their questionnaire, they would have had less motivation to respond. It was too difficult to remove these GPs from the automatic distribution process. Of those who responded, 11 said they had received it, while one wasn't sure, but couldn't find it. Of these 11 who had received it, nine had read it and two had used it. One said she had contacted agencies from the information given in it.

Only three people offered ratings for the usefulness of the map, 1, 2 and 3. However the one who scored the map at three, commented that she wasn't sure about its usefulness because she *'usually refers to S. Mental Health team or G. Valley Care team anyway - they are very good.*

A further respondent commented that the map

'helps to rationalise a personal network. Operate on the basis of their locality and thus availability to transport, proximity to childcare for appointments also'

11.2 Cross-skilling and networking opportunities for GPs and specialist services and agencies.

Six networking and cross-skilling meetings were held in the following areas:

K/B.

M/B.M

K/W/L/R.

C.

S.

S.

The two best attended meetings were those in M. and K. etc, which attracted respectively 8 GPs and 14 service providers and 9 GPs and 16 service providers. The format for these meetings was to allow one GP to present a case study of a patient, her/his management strategies and concerns, which was followed by each provider describing the work of their agency and how they could contribute to the management of the problem. GPs then joined the discussion.

11.2.1 Immediate impact-feedback from session evaluation forms

As some GPs who did not participate in upskilling meetings, attended network meetings if they were local, the overall participation in these meetings exceeds that of the project participants. 39 GPs participated and 87% GPs (34/39) completed evaluation forms, while 90% (61/68) of providers completed the forms. GPs were unanimous and service providers almost unanimous, that the material presented was of direct relevance to their practice or agency and 100% of both GPs and providers would recommend the meeting to their colleagues.

The majority of GPs (over 75%) believed that they were more aware of how to access services in the community, manage patients with these problems and more aware of physical and emotional indicators. While all of the GPs believed that the style of the session suited the subject matter very well, providers were less certain, with around 15% being unsure and 7% disagreeing. This can be explained, because only one case study was presented, and if it concerned child abuse, workers from domestic violence agencies were less able to present the relevance of their agency to the presenting problem. It may be better in future to present more than one case study, allowing the other agencies to contribute more directly.

The great majority of providers believed they would use information from the meeting in the next month. A majority agreed the session had increased their communication with GPs, with between 6-40% feeling unsure and from 6-10% disagreeing.

11.2.2 On reflection- feedback from the post-training respondents

Respondents were asked to reflect on the usefulness of the meetings, and to rate them using the same 1-5 rating scale as that referred to above. Overall the meetings were rated on average 1.6, which is generally useful.

In summary, these opportunities to network were viewed positively, slightly more so by participating GPs, but also by community workers. In some places, workers had not met each other. Some GPs and specialist workers expressed the wish verbally that the meetings could be ongoing, so that they could meet more regularly. The challenge remaining is to find ways of encouraging greater participation by GPs.

11.2.3 Reported changes in referral practices

Prior to the training, most (13) GPs reported they used at least one form of referral service for one of the three issues. Eight respondents reported having difficulties with some referral agencies, commenting on cost, accessibility to patients and perceived competence or attitudes of referral agency staff.

Over half of the final respondents reported greater awareness of resources and willingness to use them when needed, and a few that they have already tried new agencies

'more likely to involve specialist help'

'better use of local resources (once I knew what they were happy to deal with)'

'increased incidence of paediatric referrals'

'have received help from CPS in advice on matters, especially when to report..'

'I tend to press perpetrators more firmly to seek group treatment'

11.3 Upskilling opportunities in:

(a) recognising and detecting patients with domestic violence and sexual abuse

(b) managing patients with sexual abuse and domestic violence issues

In the pre-training questionnaire, GPs reported that few of them had acquired the necessary skills in the areas of domestic violence and sexual abuse. Most were interested in furthering skills in crisis counselling of victims (12) and enhancing their communication skills (12). These are dealt with in section 11.5.

Six sessions addressed the various aspects of the focus issues:

- An introductory launch of domestic violence and sexual abuse topics
- Identification, engagement and referral of men who use violence and abuse
- Identifying and responding to sexual abuse-past and present
- Women and violence RACGP workshop
- From victim to survivor: women and violence
- The relevance of forensic medicine to general practice in these areas.

Using the same numerical score (1-5) as that outlined above, GPs responding to the post-training evaluation reported that the most useful sessions were those on Women and Violence (RACGP) and From Victim to Survivors (both 1.3). This was followed by those on Child Protection and Community Policing, and Identification, Engagement and Referral of Men using Violence, which were both rated 1.4. The last was most probably useful because it is a very new area for GPs to consider and many had not realised that management and referral options for men existed. The next most useful were sessions on Identifying and Responding to Sexual Abuse; Crisis Counselling and GP Management of Vicarious Trauma (1.5); GP Management of Child Survivors of Domestic Violence and Sexual Abuse and the Relevance of Forensic Medicine to General Practice (1.6). The launch was rated 2, but this shared a CME session with male sexual impotence and was therefore diluted in its impact and also furthest from memory.

11.3.1 Immediate impact

The evaluation below is derived from the sessional evaluation forms. As the RACGP CME sessional evaluation forms have evolved, the results format has altered from percentages to open-ended feedback. The early format asked GPs to agree or disagree (strongly if preferred) with statements about the session. In most cases, unless it was noteworthy, the categories for strongly agree and agree etc have been merged.

1. Introductory session - GP Management of Domestic Violence and Sexual Abuse (Pt 1)

Dr G.M. RCH and Male Sexual Dysfunction (25 GPs)- May 14 1997.

Because of the difficulty in getting sponsorship for the first session, this session joined one, which dealt with an intra-penile injection for male sexual impotence. This may have seemed a curious juxtaposition. The intimate abuse topics were presented first.

Of the 22 respondents, the majority (77%) agreed that the material was relevant to their practice. 78% agreed that their diagnostic skills had improved and they would be in a better position to manage patients with these problems. They agreed they were now more aware of the management options. They would all recommend the session to other doctors.

2. The Identification, Engagement and Referral of Men who use Violence and Abuse

June 26 1997 (12 GPs) Ms L. S., M**** CHC.

Following this session (which included a man who had previously used violence and spoke about his long journey to controlling his violent behaviour), 89% of respondents agreed that they felt more confident with the topic. 78% felt more confident to identify a man using violence; 100% agreed they were more confident to engage with a man using violence, knew more management options and were more aware of resources and referral options for men. All would recommend the session to other GPs.

3.Identifying and Responding to Sexual Abuse- Past and Present August 13,1997,

(15 GPs) Ms P.V. and Ms J. F., CASA

Following this session, which was facilitated by workers from a local Centre Against Sexual Assault, 100% of respondents agreed that they felt their ability to support survivors of sexual assault had increased. 33% agreed that their attitudes and values about the topic had been challenged, 40% weren't sure and 27% disagreed. However, their previous attitudes, which may have been appropriate, hadn't been elicited. 87% felt more confident in identifying and responding to victims and knowing resources and referrals, while 13% were unsure. All would recommend the session to fellow GPs.

4. RACGP Women and Violence Workshop, Oct 9, 1997 (16 GPs) Dr E.H.

This session was evaluated and analysed by the RACGP staff with their standard form.

Participants reported that their knowledge of the identification and treatment of victims of violence against women had increased from 'a little' to 'significantly', with an average number reporting a moderate increase. GPs comments included that it was a 'good session' and that 'identification and empowerment were the major issues'. The pre-reading was appreciated and GPs received the college manual at the workshop. One GP who wasn't able to attend, but received the handbook later, reported that the handbook was very informative.

5. From Victim to Survivor, 15 October 1997 (11 GPs)

At this session, four women who had suffered incest, rape or domestic abuse told their stories and allowed GPs to ask questions. There was unanimous agreement (55% strongly agreed) that their ability to support survivors of sexual assault had increased. 100% agreed (36% strongly) that their ability to support victims of domestic violence had increased. When asked ways in which the session was relevant to their practice, GPs reported greater awareness of the range of presentations, the victim's feelings and the need to ask direct questions. The session was described as "a wonderful insight into the strength of women to make positives from horrific experiences". GPs reported that their knowledge of what would help the woman, (particularly through listening and validating her experiences) enhanced their confidence to manage the issues. GPs would

recommend the session because of the insight into victims' perspectives of GPs and the women's own experiences of what had helped. Two GPs called it 'excellent!', others 'fantastic', 'interesting' and one 'stressful'.

6. The Relevance of Forensic Medicine to General Practice, Oct 30, 1997 (18 GPs) Dr J.G., Consultant, Victorian Institute of Forensic Medicine

Only ten GPs completed this open-ended evaluation, one commenting that the new RACGP evaluation form was too difficult! GPs commented that the major relevance to their practice lay in understanding how to assess critical evidence better, to document evidence effectively and what victims need of you. They reported that they would now contact the Institute for Forensic Medicine if they had any medico-legal queries about sexual assault and domestic violence cases. GPs outlined a range of circumstances where the correct medical terminology in court reports was crucial. Doctors understood that the success of the case may rest on correctly documented forensic evidence, but also did not 'want to be laughed out of court'. Their confidence in writing court reports was enhanced by understanding how the reports would be used, how they should be set out, in separating examination and opinion, understanding how to use the correct terminology and use of photographs and body charts. GPs reported a wide range of new injury interpretation strategies and would recommend the workshop to others because GPs were not well trained in forensic practice, they would get a more organised approach but mostly it was 'excellent', 'useful' and 'practical' advice. Attending GPs received a forensic manual developed by the trainer.

11.3.2 The impact of training on identification and management skills:

11.3.2.1 Reported changes in knowledge and attitudes

GPs were asked whether they agreed, were unsure about or disagreed with a range of key attitudinal questions about the three issues tackled in the project (see Appendices).

One question in the pre-training questionnaire, (Q. 23) was omitted because it was not covered in the training and two further questions (Qs. 22 and 23) were added to the later questionnaire because they were referred to. The percentage responses of the eleven GPs who completed both questionnaires are reported first and then the percentage responses of all those who completed the first survey (15) are compared with all those who completed the second (17).

Attitudes:

Alcohol is the cause in the overwhelming majority of cases of domestic violence (disagree). Alcohol is not a cause, but is only associated with domestic violence in 50% of cases.

	Disagree		**Unsure**		**Agree**	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	25	33	50	40	25	27
Post	**64**	**71**	**9**	**18**	**27**	**12**

Children sometimes behave in seductive ways, therefore should bear some responsibility for sexual abuse (disagree) Even if children are perceived to be seductive, they are not held to be responsible for their own sexual abuse.

	Disagree		**Unsure**		**Agree**	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	88	93	12	7	0	0
Post	**100**	**100**	**0**	**0**	**0**	**0**

Professional people rarely experience domestic violence (disagree)

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	75	87	25	13	0	0
Post	**91**	**94**	**9**	**6**	**0**	**0**

Men who abuse their partners are aggressive people in general (disagree).

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	75	73	0	7	25	20
Post	**90**	**88**	**10**	**12**	**0**	**0**

The best advice to offer a woman in a domestically violent situation will always be 'to leave'(disagree)

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	50	33.3	36	33.3	12	33.3
Post	**56**	**47**	**10**	**12**	**34**	**41**

A mother always knows when her child is being abused (disagree)

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	88	87	0	0	12	13
Post	**91**	**94**	**0**	**0**	**9**	**6**

Most rapists are strangers

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	100	100	0	0	0	0
Post	**100**	**100**	**0**	**0**	**0**	**0**

Child abuse is very common in families with domestic violence (agree)

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	0	0	37	27	67	73
Post	**0**	**6**	**36**	**29**	**64**	**65**

It is a good idea to ask questions about domestic violence and sexual assault as a matter of routine (open, agree preferable)

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Pre	25	20	50	47	25	33
Post	**0**	**6**	**27**	**18**	**73**	**76**

Relationship counselling works well for the majority of couples where the man is violent (disagree)

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Post	**55**	**47**	**45**	**47**	**0**	**6**

In non-life threatening cases of domestic violence, it is never appropriate to break the rule of confidentiality without obtaining the woman's permission (agree).

	Disagree		Unsure		Agree	
	(% of 11)	(% of all)	(% of 11)	(% of all)	(% of 11)	(% of all)
Post	**27**	**24**	**9**	**24**	**64**	**52**

In summary, most GPs are non-judgmental about victims and understand that much violence occurs in the home. Whilst there is no assumption that GPs would do so, it is encouraging the number who respond that routine questions about violence should be asked. However, it is of some concern that a number are still unclear about the strong association between domestic violence and child abuse, that alcohol does not cause violence, the undesirability of marital counselling when violence is present or always advising a woman to leave and the importance of confidentiality. This may be because the points were insufficiently emphasised.

Knowledge about the population prevalence rates of violence towards woman, rape/sexual assault and child abuse

The following table displays the percentage of doctors (pre and post-training) who estimate the rates of domestic violence, sexual and child abuse to be one in five, one in ten etc.

Issue	Domestic violence (actual rates **1 in 5**)				Rape, sexual assault (actual rates **1 in 5**)				Child abuse (actual rates **1 in 5**)			
		(% of 11)		(% of all)		(% of 11)		(% of all)		(% of 11)		(% of all)
Pre	1:5	**25**	1:5	**47**	1:5	**0**	1:5	7	1:5	**12**	1:5	**33**
	1:10	50	1:10	40	1:10	50	1:10	60	1:10	50	1:10	47
	1:20	25	1:20	13	1:20	12	1:20	13	1:20	1	1:20	7
	1:50		1:50		1:50	25	1:50	13	1:50	2	1:50	
	:100		1:100		1:100		1:100		1:100		:100	
	:1000		1:1000		1:1000	12	1:1000	7	:1000		:1000	13
										25		

Post	1:5	64	1:5	53	1:5	9	1:5	23	1:5	55	1:5	59
	1:10	36	1:10	47	1:10	73	1:10	53	1:10		1:10	29
	1:20		1:20		1:20	9	1:20	18	1:20	36	1:20	6
	1:50		1:50		1:50	9	1:50		1:50		1:50	
	:100		:100		:100		:100	6	:100		:100	6
	:1000		:1000		:1000		:1000		:1000	9	:1000	

As with the attitudinal questions, the recommended answers are all in the desired direction after training. It is not surprising, however, that a few GPs are less successful in identifying either sexual or child abuse, given their perceptions of the population prevalence rates.

11.3.3 Reported changes in the identification and management of domestic violence including men using violence, adult rape and sexual abuse.

Identification practices:-beliefs about health effects pre- and post-training

Domestic violence

Pre-training: All GPs cited depression as a symptom, seven cited anxiety, six cited physical injuries, five - poor self-esteem, four alcohol and drug abuse, two multi-system disease or health problems and one each of stress, chronic pain, agoraphobia, educationally backward, impaired sexual function. No-one mentioned gastro-intestinal problems, headaches, eating disorders or suicide attempts.

Post-training: Whilst almost all GPs cited depression and anxiety again, it is a noteworthy gain that most now also cited vague somatic and gastro-intestinal symptoms. GPs were not asked about how men might present, prior to training. They were now aware of depression, unexplained injuries, eg to metacarpals or facial scratches, anger management or drug and alcohol abuse as possible presentations by men using violence.

Sexual assault

Pre-training: Twelve GPs cited depression with a further person using the term 'emotional difficulties'. Nine cited relationship or sexual difficulties, six cited anxiety, five poor self-esteem, two STDs two alcoholism or alcohol and drug abuse, and only one doctor mentioned each of suicide, PND, chronic pelvic pain, pain attacks, psych disturbance, inappropriate guilt, anorexia nervosa, tiredness, malaise. One respondent mentioned unwanted pregnancy. No-one mentioned anxiety on intimate examination.

Post-training: Again, whilst most cite depression or anxiety, many more are now referring to urinary tract infections, abdominal or pelvic pain, sexual problems and STDs as possible presentations.

Changes to management practices

Domestic violence:

Working with women experiencing violence

Almost all GPs commented on their increased confidence to ask direct questions about abuse if they suspected it. Several reported their greater openness to or suspicion of the possibility that domestic violence may be the underlying issue and this connected with their increased knowledge of likely presentations, eg recurrent vague somatic symptoms. A couple commented on their increased confidence in their counselling skills and several commented on their increased knowledge of resources and referral agencies. Two GPs reported no change.

Working with men using violence

Several GPs commented on their openness to the possibility

'more likely to raise it as an issue with men presenting with injury or relationship problems or depression

They also mentioned their awareness of treatment or management options, citing the Men's Referral Service (telephone counselling and referral) and the behaviour change groups at M**** Community Health Centre. One GP responded that his practice had been *'greatly enhanced'* Three GPs said no change, one responded *'don't normally see them'* and one did not respond.

Rape and sexual assault:

Five people reported no change. One commented *'I find if the patient is willing to disclose, they do so without direct questioning'*. Several mentioned being more open to the possibility of sexual abuse and asking direct questions. A few mentioned having more confidence to respond or to counsel and having resources or referrals to offer. More empathy for victims and making time and opportunities for disclosure was also mentioned, which is possibly linked to the positive victim to survivor session referred to in 11.3 no.5 above.

11.3.4 Reported changes in perceived identification rates for a three month period

The following table reports percentages of GPs reported rates of identification of women or men experiencing domestic violence or sexual abuse in the three months prior to the final session. It is not clear if these are victims or perpetrators.

Rates	Domestic violence (%11)		Domestic violence (% all)		Rape and sexual assault (%11)		Rape and sexual assault (%all)	
	Female	Male	Female	Male	Female	Male	Female	Male
Pre	55% (1-5) 27% (6-10) 9% (11-20) 9% (20-50)	55% (0) 45% (1-5)	53% (1-5) 33% (6-10) 7% (11-20) 7% (20-50)	67% (0) 33% (1-5)	27% (0) 64% (1-5) 9% (11-20)	93% (0) 7% (1-5)	27% (0) 66% (1-5) 7% (11-20)	93% (0) 7% (1-5)
Post	**9% (0)** 64% (1-5) 18% (6-10) 9% (11-20)	**82% (0)** 18% (1-5)	**12% (0)** 47% (1-5) 12% (6-10) 6% (11-20)	**76% (0)** 24% (1-5)	**36% (0)** 27% (1-5) 27% (6-10) 9% (20-50)	**64% (0)** 36% (1-5)	**24% (0)** 41% (1-5) 18% (6-10) 6% (20-50)	**59% (0)** 41% (1-5)

It is easier to change attitudes than behaviour. However, it does seem that the percentages of doctors identifying between 1-10 women experiencing domestic violence and men experiencing sexual assault has risen among the eleven GP respondents. Some rates do appear to have fallen.

In summary, GPs have widened their alertness to possible presentations of domestic violence and sexual abuse and have shifted in their attitudes. A few have reported increased confidence in their counselling skills and their knowledge of referral agencies. The rise in reported identification rates

are modest with two notable exceptions of GPs who have increased already good rates of female identification.

11.4 (c) improving the recognition and management of the needs of children who are survivors of violence and abuse

Prior to these sessions, the analysis of the pre-questionnaire suggested that awareness and identification of child abuse was lower than that of domestic violence or rape among this group of participating GPs. This corresponds to the lesser knowledge reported above about prevalence.

11.4.1 Training sessions

GP Management of children who are survivors of Domestic Violence and Sexual Abuse 17 Sep 1997 (17 GPs) Dr A.S, RCH

All of the 15 GP respondents agreed (about a quarter strongly agreed) that the style of presentation suited the subject matter and the topic was directly relevant to their practice. 67% felt more confident to consider the diagnosis of child sexual assault and 73% to handle it, should it arise. The remainder was unsure about it. 87% agreed that they were more aware of their obligations as a mandated notifier, 6% were unsure and 6% disagreed. All would recommend the session to other GPs. Comments on the meeting were mostly positive, but one GP, not yet fully confident said 'what happens after you've identified it? Counselling techniques would have been useful!'

Child Protection and Community Policing Dec 4, 1997 (17 GPs) Snr Sgt. LB and Ms A.H.

All 17 GPs agreed, with over half strongly agreeing, that they were now more aware of the role of the Community Policing Squad (CPS). 94% agreed (half strongly) that they were now more aware of the role of the Child Protection Unit. 6% disagreed.

Three GPs reported their previous knowledge reinforced, two GPs commented on understanding their responsibility in mandating, two felt more aware of the consequences of reporting, and individual GPs commented that they were 'less fearful of mandatory reporting', understood the definition of 'reasonable suspicion', that 'the child is the most important consideration' and 'reporting is my duty'. Fifteen GPs commented on when they would report, most referring to having 'suspicion', 'concerns' or if the child was 'at risk', but also feeling more able to discuss their concerns prior to reporting, with the CPS.

The GPs would recommend the session most because it was both informative and entertaining, but also because it increased their confidence to report and the speakers outlined their role well and challenged GPs previous perceptions of their role. One commented 'GPs should work with the Police Force'

Post-training respondents rated the Child Protection and Community Policing sessions at 1.4 and GP Management of Child Survivors 1.6, both generally useful to very useful training.

11.4.2 Reported changes in the GP identification and management of child abuse:

Identifying child abuse:-perceived health effects and presentations of child abuse

Pre-training: Responses covered a wide range of possible presentations, covering physical, sexual abuse or neglect. Seven mentioned education or learning problems, six doctors mentioned depression or behavioural problems and four anxiety. Two mentioned failure to thrive/regression in developmental milestones, two physical damage; musculo-skeletal problems or retinal haemorrhaging and two poor relationships/withdrawal from peers. One mention was made each of insecurity; or poor self-esteem; or tummy-aches/school aversion; lack of trust; emotional trauma, guilt; sleep disturbances/nightmares, truanting. Interestingly, no-one mentioned vaginal discharges or rashes, anal problems or sexual precocity.

Post-training presentations:

More GPs mentioned urinary tract infections, enuresis, genital trauma, school or behavioural problems. They mentioned eating disorders in former victims, along with suicidal ideation.

Management changes

Six GPs reported no change. Several reported greater awareness and openness to the possibility, eg 'aware that there is greater prevalence in the community, greater than my identification rate-why?

Management would be much the same - report to the appropriate agency, believe the child'

Several also reported that they would ask careful questions 'ask more direct questions' and report to the police or protective services. A few commented on their greater awareness of presentations.

'To suspect childhood sexual abuse in children with vague chronic symptoms or behavioural problems.'

11.4.3 Reported changes in identification rates

The pre-training questionnaire revealed that previous three month reported identification rates of the 14 respondent GPs were lowest for child abuse. The following table presents follow-up information about the three month identification rates prior to the final training.

Child abuse identification				
	(%11) **girls**	(%all)	(%11) **boys**	(%all)
Pre-training	45% (0) 55% (1-5)	40% (0) 60% (1-5)	73% (0) 27% (1-5)	67% (0) 33% (1-5)
Post-training	**36% (0)** 45% (1-5) 9% (6-10) 9% (11-20)	**41% (0)** 47% (1-5) 6% (6-10) 6% (11-20)	**64% (0)** 36% (1-5)	**71% (0)** **29% (1-5)**

It appears that there was an increase in the numbers of both girls and boys suffering child abuse who were identified after training. In relation to the prevalence rates the numbers are modest, but it is pleasing to see that a few GPs have notably improved their rates of the identification of girls.

11.5 (d) crisis counselling and assessment

11.5.1 Sessions offered

Crisis counselling Nov 13, 1997 Ms.C.M. (25 GPS)

Ms M. presented the family systems model of counselling which includes reference to family of origin and children's roles in the family system. She also presented her view of other counselling models across a spectrum from GP support to pro-active change agent. She discussed the nuances of decision making in regard to mandatory reporting.

This session offered skills highly valued by GPs and stimulated some debate, particularly about mandatory reporting. This is reflected in the GPs' assessments. 75% of the 23 respondents agreed that they would have a greater awareness of their goals in a counselling session. 20% were unsure and 5% disagreed. 70% agreed, 25% were unsure and 5% disagreed that they would be more aware of the importance of their own beliefs. The relevance to GPs own practice was expressed in a wide range of answers: a possible GP counselling role (although one acknowledged '*too specialised a skill for me to do*'); a framework (the family systems model); a range of skills- types of questions etc; methods to stimulate change in the patient; and an increased awareness of the diversity of counselling approaches.

Several ideas and techniques stood out from the session. One of most commonly mentioned by GPs was the notion of giving patients homework. Others included the idea of the individual in a family system, empowerment strategies and questions and the useful advice to GPs to '*never work harder than the client*!'

When asked about why they would recommend the session, GPs answered that much of general practice involves people's relationship difficulties, that counselling is difficult and draining, a deficit in student medical teaching, the session is 'relevant' 'interesting' and offers a systems perspective and concrete approaches to counselling. One GP suggested it required more time.

11.5.2 Reflections - Impact of the crisis counselling session

GP respondents to the post-training questionnaire rated this session 1.6, generally useful.

When asked more specifically how their knowledge and skills in crisis counselling had altered, most responded with increased confidence, but also specifying their appreciation of alternative frameworks for managing counselling:

'made me define a structure and management of such a role more precisely and consider alternatives'

'I found this session very valuable, the 'stance of curiosity' to allow (patient) debriefing; how to break cycle

'new techniques- setting specific goals, homework for the patient'

Some also mentioned their increased access to networks and referrals when needed.

11.6 (e) assisting in the reduction of vicarious trauma associated with domestic violence and sexual abuse

In the pre-questionnaire, twelve of the fourteen respondents reported having experienced stress due to dealing with these issues and eleven indicated that they would like to be involved in any project-organised opportunities for debriefing and peer support.

11.6.1 Impact of the vicarious trauma session

The 12 respondents scored this session at 1.5. When asked what they believe worked best to relieve stress in GPs in general, most respondents referred to opportunities to debrief and the importance of peer support networks:

'ability to debrief with colleagues -easier in group practice'

Other suggestions included a mentoring system, knowing the limits of one's capacity,

structuring time out and leisure, sharing the management, and having referral agencies to send patients to, particularly 24 hour services *'more available after hours services'*

When asked what they would do to relieve their own stress, doctors mentioned how they could achieve peer support or debriefing-

'muster up support for a weekly meeting'

' encourage patients to book longer consulting times'

'be rational, share responsibility, be clear who 'owns 'problem'

'increase debriefing and networking opportunities', although one person said

'unable to get spare sessions-they get filled. I do regularly debrief with professional colleagues informally'

This session provided opportunities for a good exchange of views about helpful strategies for GPs, and the division with possible strategies for enabling good peer support.

11.7 (f) Provide for and foster GP peer review and support

The duration of this project has actively facilitated GPs who are interested in this topic to meet regularly over the year to discuss the issues. This networking strategy has allowed GPs to present a case to both their colleagues and to specialist providers for discussion. The consultants interviews with GPs indicates that this process has been viewed positively by those GPs who have presented.

As the project has only just finished, it is not possible to assess yet how the division may be able to facilitate GPs' expressed needs from the final session about peer support. However, it can be

said that the project has allowed for expression and confirmation of GPs expressed needs for peer support.

11.8 (g) Raise the profile of this topic and associated problems within the general practice community

This is difficult to assess effectively. The process which allows the dispersion of ideas throughout the GP community is mostly informal and unmeasurable. There has been a little press coverage of the project towards the end.

12. Project benefits according to specific criteria:

(a) *Enabling GPs to network more effectively with each other*

Staff regarded the increase of doctors professional networks as one of the notable achievements of this project. The format of this project, timetabling monthly sessions enabled GPs interested in this topic to meet regularly. Individuals GPs have informally commented that this is beneficial. One felt that it was a benefit, because as a rural GP who lives alone, it allowed her to socialise with a wider group of peers. Another GP commented that one unexpected outcome was that she *'got to know other GPs much better'*. The project manager noted the ease with which doctors spoke to each other by the end of the project.

(b) *Enabling GPs to work more closely with community health services, other community services, non-government agencies and community organisations*

The project reference group also noted the benefits of both workers and GPs and workers themselves meeting, expanding all of their professional and personal networks. Wider community reference group members felt confident that ultimately this would not only benefit GPs, but also their patients. Reference group members believe the networking needs consolidating. This could be facilitated by the division organising regular networking meetings between GPs and community specialist providers.

Refer to the cross-skilling and networking activities outlined above in section 11.2

(c) *Enabling GPs to become more actively involved in health policy decision-making*

Not particularly relevant. Some participating GPs already belong to regional and local family violence networks. GPs who have been participating in the project may now have more interest in policy related to these issues, should they be offered a role.

(d) *Enabling GPs as a group to respond to local health issues*

Violence and abuse in the home and family relationship breakdowns were identified as local health issues in the division's needs assessment document 'Health Needs". Reference group members were very pleased with the numbers of GPs who participated in the project. They believed that the project had successfully challenged doctors, *'broadened their minds, taken them out of their comfort zone and extended their value systems and beliefs'*. While the group recognised that this had been uncomfortable for some GPs, it was seen as beneficial for both patients and doctors. The breadth and duration of the project have allowed a sizeable proportion of the divisions members to gain the knowledge, and some of the skills needed to respond to these issues, in ways they have defined themselves.

Overseeing the project has strengthened the capacity of the division to respond to the issues also. The reference group commended the fact that the division had initially considered the issue relevant, but more importantly, were pleased with the awareness and positive ownership expressed by the division's board toward the success of the project. The group considered this ownership an achievement of the project. They believe the project's effects need to be maintained and this is a remaining challenge for the division.

(e) *Improving the quality of health care by: improving access to health services; providing health services which are more appropriate; and responding to the health needs of disadvantaged groups.*

All adult and child victims of family violence are disadvantaged, because the shame and fear associated with abuse make it hard to disclose to anyone else, let alone a professional. This was

confirmed by the Australian Bureau of Statistics report Women's Safety Australia, 1996 which demonstrated that many female victims never report the violence to anyone (1).

The project has provided GPs with greater sensitivity to the issues facing victims and a wider range of strategies to broach the subject directly themselves, thus removing the responsibility from the patient. GPs increased knowledge of presentations and their reported increase in skills will improve their sensitivity and responses to victims who may present with suggestive symptoms. It has also provided GPs with ways to engage with the men using violence and to offer help to them also. Women, children and men should therefore have access to a greater number of sensitised GPs who can offer more appropriate services. As a result of the project, GPs have been provided with printed information and have met providers from a wide range of health and welfare services which they were not necessarily aware of prior to the project. All of these changes should have enabled a stronger and more responsive range of primary prevention services in this division.

(f) *Increasing GP involvement in preventive health or health promotion activities*

Not specifically addressed in this project

(g) *Enhancing educational/professional development opportunities for GPs*

This is a continuing medical education (CME) project and as such has offered GPs professional development skills. As referred to above in (a) the GPs' education is also viewed positively, particularly by those wider community members of the project reference group.

(h) *Increasing GP participation in educational/professional development activities*

The project has allowed the GP project manager to develop her skills as a GP educator. She and the GP focus group participants had opportunities to discuss CME approaches to the structure and content of the course. The GP project manager has attended both the networking and upskilling sessions and has observed the range of strengths and weaknesses of the design and methods.

13. Other achievements in relation to GPs, other services and the community

These have been covered fully in (a) to (h) above

14. Unexpected positive or negative outcomes

GP respondents' feedback included these comments

'consolidated some perceived views on the subject'

'good to hear male 'survivor' of being a male perpetrator'

'I was enlightened by participants openness in their presentation'

'couldn't believe how much I enjoyed it'

'the forensic medicine issues were a bonus'

'working with project staff very rewarding. I gained a lot more confidence in this area which was uplifting'

'very well run and sorry I was unable to attend all sessions. Excellent!'

'I expected to learn more effective methods to communicate with victims but I had not expected improved communication with perpetrators'

The clear articulation of the need for debriefing and support

While the GP project manager was not surprised, reference group members felt that the strength of GPs' stated need for support was unexpected. One expressed surprise that all other emergency professionals have such support built in to their professional management, but this is not yet developed for GPs. They expressed concern at the level of reported stress and anecdotal suicide rates of GPs. They wanted this to be followed up as a priority. Members expressed support for a proposal before the divisional board for the development of opportunities for GPs to debrief.

A GP curriculum about men using violence (but not yet a consistent overall plan):

A positive outcome of this and one other similar project (North-West Metro division) was the development of a curriculum for training GPs in the identification and management of men using violence. Fortunately, the same team of trainers from Melton CHC was approached by the two divisions for this training in the same period of time. Despite the absence of any published data about what men who use violence have experienced when they go to the GP, the trainers had a wealth of experience with such men and were able to devise a training program which had a significant and beneficial impact on GPs. Many GPs reported that they had never considered that work with men was possible nor that any such violent men could change. A possible negative outcome is that the curriculum addressing men using violence is not yet integrated with approaches to the needs of female victims and their children. There are thus both ethical dilemmas and the danger of collusion or contradiction. There is no published work on this yet in Australia or overseas, as it is a very developmental area.

Affirming the strengths of using consumer testimony for teaching

Related to this, both GPs and staff considered that hearing the stories of victim/survivors would be important, therefore a female survivor on the project reference group and three other women were recruited to tell their stories to GPs, which was a beneficial experience for them. They reported that it was positive having GPs listen with respect and congratulate them on their bravery. It was also positive for the GPs.

15. Main factors contributing to the achievements of the projects objectives

The strength of good staff

The Rural division has chosen to employ staff with strong backgrounds in education and community development. There is also a 'culture of excellence' which ensures that high standards are expected for each and every project. The project officer brought with her experience in community policing which brought her into contact with both domestic violence, sexual and child abuse. The project reference group considered that her organisational skills were excellent, which meant this contributed to the success of meetings. They also affirmed the importance of the knowledge and contacts she brought with her. Her organisational skills *'inspired confidence'* that meetings would be well run.

The strength of a responsive design

As a result of her background, the project development officer, who was committed to the project, developed the design through the use of focus groups with interested GPs. This ensured that the design was sensitive to the real 'felt needs' of the target group. She and the project officer consulted widely with community stakeholder groups. The duration of the project ensured that issues were regularly and systematically raised with GPs over the year. The project officer ensured that fliers and announcements at each session advertised the next. Shifting the location of the sessions all over the division meant that GPs in any corner of the area had opportunities to participate, at any time. This resulted in the proportionally large number of GPs who were involved with the project at least once.

In addition, staff mentioned that participant educators responded very positively to the project aims and design and were very willing to participate. Staff also commented on the contribution made by the experience, expertise and willingness to input of the project reference group and the consultant evaluator.

16. How the project could have been improved (or could be next time)

Respondents feedback

'Cognitive therapy may be a useful followup'

'more input of victims of such abuse if they are willing'

'needs to be a regular part of the CME program'

'more liaison with co-workers in the field'

' time is an issue - video program as a package which could be viewed at home by GPs'

'Follow through with individual psychotherapy strategies would be useful! I have to travel too far and would prefer block learning eg weekends or half days and I would prefer more role-playing practical stuff'.

Longer project timelines

Staff emphasised the need for longer lead times and more time overall allocated to the organisation and formative evaluation of the project, which would enable regular reflections and improvement. In discussion, the reference group believed that 18 months rather than 12 were necessary to run a project of this breadth and depth. It is also necessary to cover the wide geographical area in a rural division. Staff expressed regret they were not able to include Daylesford in the project. Reference group members would have enjoyed more opportunities to meet and support the project together, as well as the individual contact they had with the project officer.

Individual session length and location

Individual GP comments on sessional evaluation sheets indicated that GPs felt that some sessions, eg the crisis counselling sessions were too short (one and a half hours) to cover the topic, given its range and complexity. The project officer also believed that two hours or more would be beneficial. The project officer believed that a narrower focus for the project could have allowed greater depth of learning to be reinforced over several sessions on the same topic. A reference group member/educator noted that sessions in restaurants can be diversionary and both GP and educators' attention can stray to waiters and food. However, they recognised that attendance in the evenings after work can necessitate providing food, particularly in rural areas where GPs cover long distances.

Eliciting knowledge deficits

More emphasis could have been placed on mandatory reporting if the extent of GPs lack of knowledge had been fully appreciated.

Individual learning plans

None of the final respondents had yet been able to find time for individual learning opportunities offered by the project, However, ten GPs indicated that they would still like to be able to do so. When asked in what areas, six outlined counselling (two specifically cognitive behaviour therapy), two- men's anger management and one- patient management skills.

Consistency across the curriculum

The consultant has observed the difficulty of coordinating sessions so that there is overall consistency between sessions. This is not a view shared by staff, although reference group members were concerned at articulating the possibility of collusion and secrecy, when GPs see both parents and children. There is the danger of contradictory sessions, where the approach in one session contradicts that of another - eg a 'victim-blaming, ie the nagging wife' approach in the counselling session contradicts the empowerment advice in the session on violence against women. This could be avoided if someone oversaw the curriculum of the entire project - eg a specialist training agency such as the Domestic Violence and Incest Resource Centre. This could ensure that the curriculum approach was consistent across all teaching about women experiencing violence, men using violence and their children (or other possible patterns, eg homosexual violence etc). The complex ethical dilemmas which GPs face when dealing with all members of the family and the possibility of conflicts of interest needs to be addressed. This is only now being recognised as an issue overseas, so there is little awareness of how to teach about it. The first guidelines to address it were published late in 1997 in the US.

The need for reinforcement after project completion

Reference group members emphasised the importance of reinforcement of the messages provided by the project. They recommended that the division consider followup sessions, updating the service maps regularly, reinforcement through the divisional newsletter and regular networking and peer support meetings.

17. Main lessons learnt as a result of the project

Change is possible

GPs want to be upskilled in these areas. The results of the project confirm that it is possible to change knowledge and attitudes and even affect some reported behaviour change. Behaviour change in these complex areas is possible, but requires consolidation and time.

Establishment time is important

It is important to the success of a project to establish a reference group of stakeholders who will support the project officer. Time needs to be built into a project design to allow this and other establishing activities to be undertaken.

GPs should contribute to the design.

CME project designs which draw on potential participants felt needs assist the project's potential to fulfil its objectives. Employing staff with educational, research and community development skills also helps the development process.

GPs need peer support and debriefing

This project confirmed what is becoming clear in other areas of general practice. GPs have a changing environment in which greater numbers are expected to respond to the growing psychosocial need of their patient community. In addition to life-threatening illnesses, GPs must respond to the underlying issues of unemployment, suicide, family violence etc which affect their patients psychosomatic illnesses. The growing stresses of these demands require backup support and GPs are asking for opportunities to debrief and for greater opportunities for peer support. The reference group supports the divisions attention to this request from their membership.

Networking with the wider primary care community benefits everyone

The success of the networking sessions confirms the desire for GPs and other providers in the community to meet each other 'put a name to a face' and clarify the role of an organisation. It remains to be seen whether GPs will refer more consistently and appropriately. This is an opportunity for the division to take a lead in primary care networking.

Consistent change requires consolidation

Studies overseas with nurse training in domestic violence identification demonstrated that if the messages from training are not regularly reinforced, they are lost. Updating resources and offering refresher courses and opportunities for further learning are important if the impetus is not to be lost.

SUMMARY AND RECOMMENDATIONS:

The support of the division, the strength of the project staff and reference group, the project design and implementation have all contributed to the success of this project. The success is most notable in the number of GPs from across the division who have participated, in the gains in knowledge and attitudes reflected in the evaluation data and in the reported behaviour changes. The success is also reflected in the positive comments quoted in this report in which individual GPs have expressed their appreciation of different aspects of the course.

In order to consolidate the gains, the project reference group and staff recommend the following:

That the division consider ways to reinforce the learning gains made over this project, suggesting that refresher courses be offered; information about the topics be a regular feature in the division's newsletter; and further related CME be developed.

That opportunities for peer support and debriefing, already proposed to the division be supported.

That further training for GPs on the issues related to mandatory reporting be pursued as a matter of urgency, given the lower level of knowledge about this issue. The reference group urge that this include the following: the potential conflict of interest when parents come with their children, the possibility of collusion with secrecy and the need for children to access the GP even without their Medicare numbers.

That the division continues to offer opportunities for GPs to extend their professional networks through the provision of regular networking meetings in the different locations within the division.

REFERENCE:

Australian Bureau of Statistics. Women's Safety, Australia 1996. Canberra, Commonwealth of Australia 1997. ABS Catalogue number 4128.0

APPENDIX 5

REPORT OF THE PRE AND POST TRAINING EVALUATION SURVEY OF THE URBAN GP DIVISION DOMESTIC VIOLENCE PROJECT.

DECEMBER 1997

ANGELA TAFT (MPH).

URBAN DIVISION DOMESTIC VIOLENCE PROJECT.

EVALUATION REPORT

1. INTRODUCTION:

The Urban General Practice Domestic Violence project offered all GPs in the division the opportunity to be trained to tackle domestic violence in their patient population. The project offered GPs two workshops of two hours duration; the first addressed the identification and management of women experiencing domestic violence and the second, men using violence at home. It also provided a behaviour change group to which GPs could refer men using violence, a manual of local and statewide resources (the referral database) and a collection of printed material to be either displayed in the waiting room or offered to patients individually. Sixteen GPs (just under 5%) accepted this offer. The first pair of workshops was held in May and the second in July 1997.

2. EVALUATION METHOD

The consultant designed two linked knowledge, attitude and practice (KAP) questionnaires (see attached). The pre-training questionnaire was designed to collect demographic data and anonymous identifiers, in addition to KAP questions, which would allow questionnaires to be matched and compared to the post-training questionnaires. The draft questionnaires were forwarded to project trainers, the project officer and reference group members for comment and amendment. Unfortunately, the time frame did not allow for adequate piloting of the questionnaires with other than the reference group prior to their distribution.

NB Two attitudinal questions to men using violence (21, 22 in the pre-questionnaire) were deleted from the final questionnaire in discussion with reference group members. In addition, a question addressing breaking confidentiality (20 in the pre-questionnaire, 14 in the post-questionnaire) was amended to be explicit about the exclusion of times when the GP believed the case was life-threatening.

The final questionnaires were mailed out and received back by the project officer. The pre-training questionnaires were sent out two weeks prior to the workshop. The post-training questionnaire was sent out between six and eight weeks after the training finished, so that participants could have a chance of putting what they had learnt into practice. Three GPs did not complete the questionnaires as they were not able to attend the second workshop on men using violence.

Fifteen of the sixteen participants returned the first questionnaire. Only eleven returned the second, including one who had not completed the first questionnaire, giving a response rate of 73%.

3. RESULTS

3.1. Participants

The sixteen respondents to this survey comprised seven female and nine male GPs. Their mean and median age was 46. Seven of the GPs practiced in moderate sized practices (2-4), three in solo practice, and two in either a large practice (over 4 GPs) or a community health centre. The GPs length of time in practice is consistent with the national trend, that is, the practising male GPs had a mean number of 21 years in practice, (one was retired and practised as an occasional locum GP). The female GPs' mean number of years in practice was five. Eleven of the GPs were full-time with four practising part-time. Only one GP reported any previous training in the subject, although this was in fact on the related topics of adult sexual abuse and child abuse.

Overall, therefore, of doctors who volunteered for this training more are male than female and more full-time than part-time. The sex ratio is similar to that of the Victorian GPs trained by the RACGP Violence Against Women Training Project in 1995-96, but different to that nationally, where more female than male GPs volunteer for training.

3. 2 Reasons for participating

Nine GPs mentioned a desire to improve their knowledge and/or skills in this area, with one GP specifying improved counselling skills. Five mentioned wanting to understand the problem

To learn what makes another person commit acts of violence

Interest in society's problems

Two GPs mentioned wanting to prevent violence. Three GPs wanted to learn more about available resources and one specifically mentioned building confidence in dealing with domestic violence. One GP mentioned his specific goal of starting a men's health clinic.

3.3. Patient populations

Doctors reported that the average percentage of women from non-English-speaking backgrounds (NESB) in their patient populations was 36%. While three GPs estimated their NESB populations to be round 10%, one said 90%, one 70-80% and three 50%. This is a very multi-cultural patient community. The proportion of Koori patients in the participant practices was minimal to none.

The participants reported that they saw on average 70 women a week. The figures ranged from 30 to 120.

3.4. Beliefs about the prevalence of violence before and after training

The Australian Bureau of Statistics 1996 report "Women's Safety Australia' reports the lifetime prevalence of women over 18 experiencing violence as 23% (one in five). The post questionnaire results demonstrate that learning was in the desired direction and a higher proportion of GPs responded with the correct prevalence rates.

Estimated rates	**One in five**	**One in ten**	**One in twenty**	**One in fifty**
Pre-training	47%	27%	13%	13%
Post-training	**73%**	**18%**	**9%**	

3.5. Beliefs about those most at risk of being abused

From the research evidence, pregnant women, those abused as children and those who witnessed abuse as a child are most at risk. Rates are high in working class populations. Whilst professional women do experience domestic violence, they are not regarded as a high risk group.

Population data does not confirm the common belief that NESB women are more at risk. Because NESB women experience many barriers to accessing services, they do not access services as readily and are therefore over-represented in crisis data, such as homicide and refuge data. They are an important target group therefore for GPs to identify and refer early.

GP beliefs may be influenced by trainers emphasising that all women can be at risk, even though the correct emphasis was placed on the high risk groups. Doctors are influenced by those who disclose to them, which in this division are more likely to be working class and NESB women.

In the table below, it is clear that the numbers of GPs knowing that pregnant women and those who have witnessed domestic violence are at greater risk, have risen.

Number of GPs	Working class	Professional women	Pregnant women	NESB women	Abused as children	Witnesses to DV
Before training	87%	53%	53%	87%	93%	67%
After training	82%	46%	82%	82%	100%	100%

3.6. Challenging attitudes to domestic violence.

The training sought to challenge some of the attitudes, which reflected common myths. The questionnaire checked to see whether fewer doctors subscribed to these following training.

The table below indicates the number of GPs who responded with recommended attitudes before and after training. There has been a positive shift towards recommended attitudes.

N.B. *Strong agreement and disagreement were conflated with agree/disagree response categories*

Attitudes being assessed	Before training (15)	After training (11)
Alcohol is the cause of domestic violence in the overwhelming majority of cases (disagree).	33%	87%
Professional people rarely experience domestic violence (disagree).	87%	73%
Men who abuse their partners are mainly aggressive people in general (disagree).	53%	55%
The best advice to offer a woman in a domestically violent situation will almost always be 'to leave' (disagree).	53%	64%
Child abuse is very common in families with domestic violence (agree)	53%	82%
It is a good idea to ask questions about domestic violence as a matter of routine with populations at risk (agree)	67%	82%
Women who live with abusive men are many times more likely to abuse their children than women who have left abusive partners (agree)	20%	64%
Relationship counselling works well for the majority of couples where the man is violent (disagree)	40%	55%
In non-life threatening cases of domestic violence, it is never appropriate to break the rule of confidentiality without obtaining the woman's permission (agree)	47%	91%

N.B. Unfortunately, whilst the recommended view concerning abusive men and general aggression is to disagree, this was counter-acted by the ex-perpetrator who provided life-testimony to the second workshop. He had been a generally aggressive man, therefore the teaching in this session may have counteracted the desirable attitude.

3.7. Reported identification rates by GPs before and after training

GPs were asked how many people experiencing violence and those using it before and after training. The table below reports the shifts in doctors' identification rates. Doctors were asked about identification over the previous two months for the pre-training rates and about **new** patients in the two months after training.

	Female victims	Male victims	Male perpetrators	Female perpetrators
Before training	13% (0) 67% (1-5),	80% (0) 20% (1-5)	47%(1-5) 40% (0)	27% (1-5) 73% (0)

	13% (6-10) 6% (11-20)		7% (6-10) 7% (11-20)	
After training	91% (1-5) 6% (6-10)	73% (0) 27% (1-5)	27% (0) 73% (1-5)	100% (0)

3.8. Perceived comfort with asking men about violence.

Participants were asked both before and after training "How comfortable do you feel bringing up issues of domestic violence with male patients?"

It is clear that almost all the responding doctors have shifted considerably in their comfort levels in approaching men using violence.

	Level of comfort
Before training	20% 'not at all comfortable' 60% 'not very comfortable' 20% 'just comfortable'
After training	18% 'completely comfortable' 46% 'quite comfortable' 27% 'just comfortable' 9% 'not very comfortable'

3.9. GP recommendations for the identification and management of domestic violence:

The questionnaire asked GPs to list up to six ways in which they would recommend that doctors identify (that is, what are common presentations) and six ways they would recommend doctors manage domestic violence. This question was asked both before and after training.

Identification of women experiencing violence:

Pre-training:

GPs are already seeing some women and therefore have some idea of the range of general symptoms with which women can present.

The most commonly mentioned identifiers were bruising or injuries (80%), closely followed by depression (67%) and anxiety (40%).

27% GPs mentioned low self-esteem, insomnia, poorly explained trauma (bruising or injuries) and alcohol or drug addiction in family (either patient or her partner).

20% mentioned vague or trivial symptoms; somatic complaints; aches and pains including headaches, and frequent visits with children. Interestingly, 20% also suggested you could tell through the woman's appearance, her dishevelled or anxious appearance.

13% mentioned frequent attendance; asking questions; and partner or marital problems. Only 6% suggested suicidal tendencies; tranquilliser requests; abdominal pain; eating problems; social isolation or jealous husband. Self-disclosure; information from relatives and friends; hyperventilation; work problems and sexual assault were mentioned once each.

Post-training:

82% GPs cited depression and 73% trauma or injury. 45% mentioned anxiety and 36% frequent attendances and vague 'trivial' complaints. 27% GPs mentioned aches and pains, poorly explained injuries and low self-esteem. 18% cited visits with children; alcohol; social isolation or financial dependency and drug problems.

Somatic symptoms; insomnia; tranquilliser requests; abdominal pain; possessive husband; sexual or work problems were mentioned once only. Oddly, man-hating and Munchausen's Syndrome by Proxy were also offered as indicators - although these were not mentioned in the training!

After training more GPs mentioned less obvious symptoms, although it would have been preferable to see more symptoms mentioned by more doctors.

Identification of men using violence:

Prior to training, 47% GPs mentioned partner disclosure, 40% mentioned either or both of drug and alcohol abuse, 20% mentioned depression, 13% disclosure by the man; a background of family violence; marital problems and attitudes to women and other GPs suggested either jealousy; fearful wife or children; poor self-esteem; poorly explained hand injuries or a criminal history.

In summary, while there was no majority opinion in the group, most relied on partners telling them or the connection with alcohol and drugs and two mentioned the man disclosing. Two merely put question marks. A few doctors considered other important clues such as depression, jealousy, hand injuries. None included suicidal ideation, previous relationship violence, socially isolated men, also common indicators in some men.

Following training, 64% cited alcohol; 46% mentioned depression; 36% mentioned somatic aches and pains and jealous, over-protective, aggressive or overbearing behaviour; 18% social isolation; attitudes to women; guilt and shame; suspicious hand injuries, poor self-esteem and others mentioned either insomnia; blaming others; previous partner violence; being brought in by police; anxiety; a background of family violence; unemployment and work injuries.

This suggests that these eleven respondents have learnt a wider range of indicators to identify men who are using violence.

Management of women experiencing violence

Consistent with other research, 53% GPs recommended general counselling and 47% general support. 47% GPs recommended referral to counselling by another professional or to refuges and 33% recommended referral to the police.

20% mention supporting the woman's choice or specifically discussing legal or intervention orders. 13% mention a safety plan or explaining her rights; the importance of believing her story; review or followup. A further 13% recommend building self-esteem while there was one recommendation for empowerment.

20% recommend treating the symptoms (depression, injuries, alcohol problems). 13% suggest couple counselling or counselling the perpetrator themselves.

There was individual recommendations of referral to a support group; explaining that the behaviour of the male partner won't change; referring the perpetrator to group; or aDVising her to leave or tell family and friends.

After training, there has been an improvement in the range of management strategies recommended by GPs from those learnt in the training project.

While 55% doctors mention general support, 46% mention referral to counselling or counselling by GPs, 46% mention supporting her choice, 46% a safety plan, checking her safety and explaining her rights. 36% mention referring or aDVising refuge; explaining or discussing legal rights or intervention orders. 18% recommend explicitly believing her; referring to support or therapeutic groups; referring the partner to a men's group or treating the symptoms. Self-esteem work; counselling the man; speaking to family or friends and stress management were single recommendations.

Management of men using violence

One GP didn't make any suggestions, while 80% suggested counselling, 40% recommended referral to a counsellor, therapist or psychologist and 27% to a men's behaviour change group. 27% suggested that they would offer anger management strategies themselves. 20% outlined general support, 13% mentioned treating depression or drug and alcohol problems; referring to

police (with women's permission and couple counselling. Explaining partner's rights, being non-judgemental; offering victim support and entering a non-violence contract were single recommendations.

The specific recommendations about counselling reflected GPs uncertainty about what to do, although some gave specific advice such as:

'encourage to listen to partner'

' encourage communication, especially of feelings, stressing the place of 'joy' as against remorse and rage..'

' discuss plan with partner when cool and calm - so when they leave, not seen as weak or cowardice'

After training, while 82% still recommend counselling, the qualifications are more specific and generally in the recommended direction:

'take a general history and discuss the specific problem'

'encourage to talk about violence, explain criminality, give information about Men's Referral Service'

'counselling separately, discuss and disperse myths about domestic violence'

'keep communication open to look at underlying issues'

'confront person, establish that abuse is a choice and can choose not to act'

'that there is a solution,... explore past childhood, explore male role models they've had'

55% suggest referring to a men's behaviour change group, 36% treating drug and alcohol problems; 27% referring to a counsellor and 18% treatment of any underlying depression. 27% suggest explaining partners rights; offering stress/anger management; general health management and couple counselling (although one GP specified only if appropriate). Victim support; legal or intervention orders; being non-judgemental; general support; offering suitable reading material; and doing self-esteem work were individual recommendations.

3. 10. Referral patterns

In the pre-training questionnaire, only 40% GPs stated that they referred to domestic violence agencies, while 80% referred to child abuse agencies.

When asked whether they had experienced any problems, 13% GPs mentioned that although they refer to DV agencies, patients then don't turn up and this is frustrating. 6% commented that getting the right agency on the phone was difficult. 20% commented that inappropriate interventions, lack of followup or liaison, lack of availability, understanding, rigid approaches and counsellors who know less than GPs are problematic.

Following training, 100% GPs agreed that '*The referral database has enhanced my knowledge of and ability to use appropriate referral agencies.*'

Eight GPs agreed, but two were unsure whether their use of referral agencies had increased. One GP disagreed.

Consequently, GPs report more confident and increased referrals and feeling that they are now much better resourced if and when they need to refer.

3.11. Reported changes in knowledge, skills and confidence

All eleven GPs agree that their *knowledge of domestic violence* has increased.

Ten GPs agree that their *skills in dealing with men using violence* have increased. Only one GP is unsure.

Nine GPs report increased *skills with women experiencing violence*. Two are unsure.

Nine GPs agree that their *confidence in identifying and managing women experiencing violence* has increased. Two are uncertain.

Eight GPs that their *confidence in identifying and managing men using violence* has increased. Three are uncertain

Consequently, the training has succeeded in responding to the GPs reasons for participating and in increasing knowledge, skills and confidence.

3.12. Stress

It is quite striking that 14 out of 15 GPs reported experiencing stress, although at different levels.

Seven of these report experiencing it all the time, frequently, 'every time I come across a case' or 'very often', while for others its rare or occasionally or infrequently.

Coping strategies

When GPs were asked how they manage the stress - seven responded that they debrief with partners or other GPs. Two see either a professional psychologist or a colleague- psychiatrist. One said 'usually I suffer', while another said they 'keep calm'

Best support for GPs

When asked (prior to training), about what could be done, six refer to some form of debriefing

'an appropriate debriefing process'

'I didn't discuss concept of debriefing for 10 years - and then realised I had only my wife to debrief to!

A few suggest more agencies for referrals, two suggested a form of telephone support, while several suggest networking with other GPs and one person proposed payment for prolonged counselling.

3.13 Educational resources

Eight GPs agreed that *providing educational resources has led to increased discussion about domestic violence with patients.* One GP was unsure and two disagreed.

Ten GPs agreed that the *educational resources were valuable to me.*

Of all the educational resources, several GPs specifically singled out the referral database for praise:

'the summary sheet for DV referral database is very handy and easy to access'

'good to have useful info on hand'

'database very helpful, thanks to F. A!!'

The Men's Referral Service resources were most popular, with nine GPs highlighting them,

MRS poster generated some requests for referral, some disclosed own violent behaviour after seeing poster'

Six mentioned the Violence Against Women booklet, five the Domestic Violence Outreach service material, three the patient health kits and three recommending the business cards (and one GP called them useless!).

The resources have clearly been useful.

3.14. General comments

Two comments referred to the time allotted to the course and the need for more time

'Overall I enjoyed the training sessions and found them useful. Nevertheless I feel much more could have been said in the second part of the training...but time ran out. Perhaps more time can be given to the speaker next time'

' Probably more time needed to cover material'

One person referred to the need for followup.

'A followup meeting must be organised'

Lastly two doctors mentioned the ongoing dilemma for GPs

'I'm always too busy dealing with the immediate problem patient presents with to probe deeper.

I need more time!! I'm too busy simply working'

'The info is terrific. Finding the time to put the info into practice is the problem'

4. CONCLUSION AND RECOMMENDATIONS

There is no doubt that this training project has strengthened the knowledge, skills and confidence of the doctors who have participated in the course, which was the reasons they gave for attending. The project staff can feel satisfied that overall they have achieved their objectives.

It is a great pity that more doctors did not participate. However, the research indicates a wide range of barriers to GPs facing this problem and many talk about not wanting to 'open Pandora's Box'. It will take a committed and sustained approach by the division and professional medical associations to see that more GPs are trained to manage a problem more prevalent than many others for which training is offered.

The question of whether the problem of stress in dealing with domestic violence is general among the GPs within the division requires further investigation.

The consultant's interviews with participating doctors echo the findings of this evaluation. However, they also echo the final comment by doctors, that follow-up refresher courses should be held. With the plethora of Continuing Medical Education offered by the division and the pressure of practice, the memory of good practice is difficult to retain.

GPs have commented that there is a need for a special course which concentrates on cross-cultural good practices. This no doubt reflects their response to the makeup of their patient population. Doctors have also agreed that the identification and management of children living with violence, an important primary prevention strategy given the strong risk of adult abuse, would be very useful knowledge and skills to have. It is very important therefore, that if these critical further areas are to be developed and the current effects sustained, followup courses should be implemented.

The valuable educational resources developed by the project should be maintained by the division and available for all GPs whether or not they have completed the training.